MECKLENBURG COUNTY LME

Needs Assessment and Service Gaps

MARCH 2008

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INTRODUCTION

About Mecklenburg County LME

Mecklenburg County LME is a single-county urban local management entity that serves 827,445 citizens. The vision of the Mecklenburg County LME is, "A Community system that empowers and supports individuals to lead healthy and independent lives."

On an on-going basis, through a variety of advisory and community committees, Mecklenburg County LME identifies needs and service gaps that promote and achieve the wellness, recovery and independence for Mecklenburg County citizens with mental health, developmental disability and substance abuse challenges and incorporates those needs into the day to day development of an accessible, responsive and quality driven community of providers and into fostering collaborations within and across community systems.

Mecklenburg County LME Committee Structure

Mecklenburg County LME has a strong, effective committee structure that expands and democratizes consumer and community participation in LME responsibilities. These committees meet monthly and are engaged in numerous tasks. Their ongoing work related to service gaps and service needs was aligned with the 2008 needs assessment process; input from each committee was critically important.

Standing Committees Include:

- Consumer and Family Advisory Committee: provides input and guidance on all policies, practices, and protocols that relate to the treatment and support of consumers and families, the development of the community of providers, movement toward best practice methodologies, the allocation of service dollars, and quality improvement initiatives.

- Planning and Collaboration Committee: provides input and guidance in the development of the local strategic business plan and in policy decisions re. system reform and community collaborations. It is comprised of representatives from CFAC, advocacy organizations, interested stakeholders, and community coalitions and partners such as Juvenile Justice, Vocational Rehabilitation, and Mecklenburg Disabilities Network.

- Best Practice Community Committees: there are four separate best practice community committees each representing a consumer continuum; the purpose of each

committee is to promote the development and expansion of evidence-based best practices and to support the integration of available community resources in the support of consumers and their person centered plans. Each committee includes consumers, family members, providers, advocates, community partners, stakeholders, and LME staff.

Mecklenburg Assessment

The current contract between the North Carolina Department of Health and Human Services (DHHS) and each Local Management Entity (LME) requires an assessment of the adequacy of the local provider community. Taking into account the county's population, the assessment must identify gaps in the service array and the number and variety of providers for each service. It must also include input from consumers, families, and community stakeholders. Additional requirements specify targeted inquiry, including regarding children's services, CAP services, serving those with different cultural and linguistic backgrounds, and an inventory of those providers willing to contribute to community emergency response efforts in the case of natural or other catastrophic disasters.

Summary of Results

Mecklenburg County LME initiated this formal needs assessment process in January 2008. The most common needs identified are summarized in the table below.

Mecklenburg Service Needs Identified in Surveys & Forums			
	Providers	Community-Stakeholders	Community Forums & Focus Groups
General Services Needed	▪ Developmental disabilities services for youth ▪ Substance abuse services for youth ▪ Dual diagnosed individuals ▪ Bi-lingual/cultural (no one population) ▪ Hours of operation ▪ Communication of available services ▪ Location of service providers	▪ Developmental disabilities services for youth ▪ Substance abuse services for youth ▪ Dual diagnosed individuals ▪ Wait times/delays in service ▪ Bi-lingual/cultural (no one population) ▪ Communication of available services ▪ Location of service providers	▪ Improved communication ▪ Quality/Competence ▪ Quality PCP development ▪ Transportation ▪ Supportive Employment ▪ Improved access (hours, services, language) ▪ Prevention ▪ Cultural competence ▪ Spanish-language services ▪ Services for deaf and hearing impaired ▪ Best Practices ▪ Location of service providers
Developmental Disabilities	▪ Many gaps identified; no one service need or barrier stood above others.	▪ Employment services ▪ Day Supports	▪ CAP ▪ Employment services

Mecklenburg Service Needs Identified in Surveys & Forums			
	Providers	Community-Stakeholders	Community Forums & Focus Groups
Mental Health	▪ Employment services ▪ Residential services	▪ Employment services ▪ Wait times ▪ Inconvenient hours	▪ Crisis services ▪ Medication services ▪ Employment services ▪ Housing services
Substance Abuse	▪ Shortage of Beds: ▪ Inpatient ▪ Residential supports ▪ Halfway house ▪ Detox	▪ Inpatient ▪ Residential & halfway house ▪ Prevention	▪ Prevention ▪ Assessment ▪ Interventions ▪ Detox ▪ Housing services ▪ Supportive services ▪ Outpatient treatment
Child & Adolescent	▪ Multisystemic treatment ▪ Sex offender ▪ Substance abuse ▪ Residential ▪ More services outside business hours ▪ Transition from adolescent to adult	▪ Sex offender treatment ▪ Substance abuse ▪ Dual diagnosed ▪ Residential support ▪ Family support ▪ More services outside business hours	▪ Services for 3-5 year olds ▪ School-based services

The information above will be communicated back to CFAC, the Planning and Collaboration Committee, and the Best Practice Committees. Each committee will provide feedback on how to approach the needs identified. A plan with measurable goals will be developed to ensure that each need is addressed over the course of the next year. Quarterly updates will be completed to track the LME's progress on each need.

CREATING AN ANNUAL ASSESSMENT PROCESS & INTEGRATING IT THROUGH LME FUNCTIONALITY

Annual Process

Integrating This Information:

Information gathered through the formal 2008 needs assessment is merely one part of the range and scope of data collected by Mecklenburg County LME during the course of a fiscal year

Data collected in this needs assessment process will be integrated into ongoing planning, quality, and management efforts that are already underway.

Next Steps for the Process:

In order to establish this as an effective management tool, the Mecklenburg County LME will also do the following:

- Upon completion and dissemination of the Needs Assessment Report, the Steering Committee will hold a "lessons learned" session. The Committee will discuss and evaluate what did and did not work well during this process, identify improvements, and determine next year's assessment process.

- Particular attention will be paid to continue to increase and enhance active consumer and family participation.

- The Steering Committee will identify ways to streamline the process in order to capture increasingly targeted information.

- The Steering Committee will continue to meet on a quarterly basis and will identify ways to better integrate the formal needs assessment process with established ongoing efforts in order to enhance and improve best practice service delivery. Special attention will be paid to ways this process can be more closely aligned with Mecklenburg's consumer and stakeholder committee structure and LME functions related to quality and provider management.

COMMUNICATING THE ASSESSMENT

Upon completion, the following steps are required:

- The final report will be submitted to the CFAC.
- The final report will be submitted to the Board of County Commissioners.
- The NC Division of MH/DD/SAS will review this document as part of its routine site visit in April 2008.
- Report results will be shared with consumers, families, providers, stakeholders, and the community via the Mecklenburg LME website, and public presentations.

RELEVANT ACCOMPLISHMENTS PRIOR TO ASSESSMENT

The Mecklenburg County LME 2007 Local Business Plan identified several gaps in services to be addressed:

- Increase the number of consumer served (MH/DD/SA and any other under-represented population)
- Increase the number of providers that embrace best practice models and that demonstrate those models through inclusion of best practice philosophy and guiding principles in their overall vision and mission and service delivery.
- Develop a continuum of services for consumers who age out of the Child system and are transitioning into the Adult system
- Expand the availability of housing options to MH/DD/SA consumers.
- Develop and implement a centralized facility based crisis service
- Develop a MH/SA Rapid Recovery Continuum
- Expand continuity of care opportunities for high risk consumers

Some of the gaps have been addressed in the RFP Process. While some of the RFP's have not been finalized at this time, the process has begun.

The following Requests for Proposal (RFP) and Requests for Information (RFI) have been completed in fiscal year 2007-08:

- Traumatic Brain Injury Treatment (January 2007)
- SA IDDT Recovery Model Best Practice (February 2007)
- DD Community Alternatives Employment Transitions (CAET Best Practice model) (February 2007)
- AMH/CMS RFP for Community Support Providers in the school system (March 2008)

The following RFP's and RFI's have been initiated and are in process but at this time have not been completed:

- Juvenile Sex Offender Treatment
- MeckCARES – Lead Community Support Provider
- MeckCARES – Respite RFI
- MeckCARES – Therapeutic Foster Care RFI

- MeckCARES – Rapid Response RFI

Additional accomplishments noted in the past year include:

- A Cultural Competency Advisory Committee was formed to help shape policy for the LME and develop a Cultural Competency Plan.

- A Marketing Plan was completed with a focus on increasing prevalence rates across consumer continuums.

- Development of a Regional Crisis Plan

- Funding received through the Mental Health Community Capacity Initiative to develop transitional housing for the identified population in order to divert consumers (when appropriate) from State facilities; consumers currently in State and or other hospital or treatment setting who have no home to return to and/or who need wrap/around 24/7 support.

ASSESSMENT PROCESS

Purpose, Goals, Authority and Responsibilities

Assessment Purpose:

To identify needs and service gaps that promote and achieve the wellness, recovery and independence for Mecklenburg County citizens with mental health, developmental disability and substance abuse challenges and to incorporate those needs into an accessible, quality provider network and a collaborative community system.

Assessment Goals:

- Incorporate feedback from family members, consumers, stakeholders, and providers into the Community Needs Assessment.
- Determine current service needs across the full service array, including special populations, and cultural and linguistic considerations.
- Determine service needs utilizing Best Practice Standards that are currently not available to Mecklenburg County consumers and to ensure that current services are being provided through the use of best practice approaches.
- Estimate anticipated need for services for the next one-two years.

- Ensure there is a stable, well-trained provider workforce available in the community.
- Examine the effectiveness of inter and intra agency collaboration.
- Define existing provider capacity: service, volume, special populations, and cultural & linguistic special needs.
- Based on current and anticipated service need, prioritize service expansion and provider enhancement efforts. Particularly prioritize crisis services and services more likely to develop or maintain community, family, and natural support connections.
- Ensure the assessment process meets all requirements outlined in the DHHS performance contract and the DMH/DD/SAS monitoring instrument.

Assessment Decision-Making and Work Responsibilities:

- The final assessment document and findings are to be shared with the Mecklenburg County Board of County Commission and the Mecklenburg County LME CFAC.
- Decision making authority regarding the assessment process and content rest with Grayce Crockett, CEO.
- Lead staff responsibilities rest with Dennis Knasel, Director of Consumer Affairs and Community Services
- A Steering Committee includes a combination of Mecklenburg County LME staff, CFAC members, and Provider Representatives from the Best Practice Committees including: LME Staff: Dennis Knasel, Jan Sisk, and Matthew Dillworth; Provider Representatives from the Best Practice Committees: Ed Payton, Libby Cleveland, Melissa McVicker, and Lori Gougeon; and CFAC Chair Ron Reeve.

  The Steering Committee met twice throughout the process, each meeting having the following purposes:

  - Meeting 1. Formed the steering committee; introduced, reviewed, and finalized the assessment purpose, goals, and process; defined the committee's role; identified preliminary areas of inquiry and service needs and gaps from the perspective of committee members. The committee members also shared the perspectives of the best practice committees which they represent.

  - Meeting 2. Reviewed data and a draft report to recommend ways to finalize the document and to contribute to prioritization.

- Other Mecklenburg County LME staff assisted in the needs assessment as required.

- Consultative assistance was provided by Watauga Consulting.

Summary of Data Collection Methods

Quantitative Data:

The following quantitative data were gathered and reviewed during the assessment process:

- Medicaid expenditure data.
- IPRS expenditure and client count data.
- Jail services data.
- NC TOPPS.
- Community System Progress Indicators published by the NC Division of MH / DD/ SAS.
- Census demographic data.
- Internal needs-related and quality management data and reports.
- Relevant local, state, and federal reports related to service needs and gaps.

Consumer and Family Forums:

Numerous consumer and family forums were conducted in Mecklenburg County:

Type of Forum	Date	Number of Participants
Mental Health and Substance Abuse Focus Group	2/10/08	14
Developmental Disabilities Focus Group	2/17/08	6
Adolescent Substance Abuse	2/26/08	13
Consumer & Family Forum	2/28/08	94
Consumer & Family Forum	3/12/08	8

Surveys:
The following three electronic surveys were administered in February and March 2008:

Target Audience	Number of Responses
Providers	123
Community Stakeholders	160
Provider CEO	44

Interviews:

Individual interview with the Program Director for regional deaf and hard of hearing services.
Individual interview with the Director of a provider representative from the North Mecklenburg region.

DATA COLLECTION & KEY FINDINGS

Census Demographic Data

The following offers relevant summary information from Census 2000:

	MECKLENBURG TOTALS
TOTAL POPULATION	827,445
MEDIAN AGE (YEARS)	35.0
Under 5 Years	66,558
	8%
5 to 9 Years Old	58,005
	7.0%
10 to 14 Years Old	57,121
	6.9%
15 to 19 Years Old	55,139
	6.7%
18 Years and Over	611,628
	73.9%
65 Years and Over	68,480
	8.3%
ONE RACE	815,402
	98.5%
WHITE	497,185
	60.1%
BLACK	248,706
	30.1%
HISPANIC ****	81,242
	9.8%

OTHER	69,511
	8.4%
TWO OR MORE RACES	12,043
	1.5%
EDUCATION *	538,272
HIGH SCHOOL GRADUATE OR HIGHER	N/A
	87.8%
BACHELOR'S DEGREE OR HIGHER	N/A
	38.1%
DISABILITY STATUS **	83,714
	11.1%
INDIVIDUALS BELOW POVERTY LEVEL	N/A
	11.3%
CIVILIAN VETERANS***	56,158
	9.2%
FOREIGN BORN	104,789
	12.7%

*** BASED ON POPULATION 25 YEARS AND OVER**

**** BASED ON POPULATION 5 YEARS AND OVER**

***** BASED ON CIVILIAN POPULATION 18 YEARS AND OVER**

****** OF ANY RACE**

Consumer and Family Forums
Stakeholder Focus Groups

Forums & Focus Groups (February & March 2008)			
Forum	Date	Number of Participants	Gaps Identified
Mental Health and Substance Abuse Consumer Forums	2/10/08	14	▪ Crisis Services ▪ Employment Services ▪ Housing Services ▪ Transportation Services
Developmental Disabilities Focus Group	2/17/08	6	▪ Crisis Services ▪ Employment Services ▪ Gaps in CAP Services
Adolescent Substance Abuse Consumer Forum	2/26/08	13	None
Consumer and Family Forum	2/28/08	94	▪ Transportation ▪ Supportive employment ▪ Improved communication ▪ Better access (hours, services, language) ▪ Quality
Consumer and Family Forum	3/12/08	8	▪ Quality of staff, staff development and retention ▪ Single entry into services ▪ Knowledge regarding available services ▪ Service duplication ▪ Multiple disability services ▪ Customized services ▪ Assessment ▪ Detox ▪ Children's services (age 3-5, school based) ▪ Services for visually impaired ▪ Changes in system

Committee Focus Groups (January - March 2008)			
Committee	Date	Number of Participants	Gaps Identified
CFAC	1/31/08	16	▪ Quality PCP Development ▪ Employment Services ▪ Quality Assessment by Case Managers ▪ Case management training

Committee Focus Groups (January - March 2008)			
Committee	Date	Number of Participants	Gaps Identified
			▪ Day Activities ▪ Staff training and quality
MH Best Practice Committee	2/7/08	16	▪ Crisis Services ▪ Medical Services to include primary doctors ▪ Employment services including follow along services and training for employers ▪ Housing Services including transitional housing, assistance with security deposits and rent, and housing for SMI consumer populations ▪ Recovery Resources including peer supports, a resource center, non-clinical day programming, consumer operated services, and more consumer and family education ▪ Clinical Services including a DBT group for consumer with an Axis II diagnosis, more availability for psychological and neuropsych assessments, prevention program for pregnant women and women with children, parenting classes, a cognitive rehab program for consumers 18-25 years old with thought disorders, step down service from Community Support, and integrated care for dually diagnosed consumers
SA Best Practice Committee	2/19/08	13	▪ Service options in all areas of the county ▪ Intervention Services ▪ Assessment services including more bilingual assessment locations, assessments available in the home/community, and deaf and hard of hearing assessments

Committee Focus Groups (January - March 2008)			
Committee	Date	Number of Participants	Gaps Identified
			▪ Detox services including non-hospital medical detox, and other detox options such as social setting, ambulatory, and medical which are all currently limited to one provider ▪ Housing Services including a continuum of care for housing including wet houses, clinically supported transitional housing and permanent housing. ▪ Supportive Services including more employment services, a drop in center, and a resource center ▪ Clinical Services including 24/7 crisis teams, training, increased adolescent services, additional options besides community support, more flexible programming, availability of professionals in hospital ER's, and training.
DD Best Practice Committee	2/4/08	30	▪ Transportation ▪ Housing services ▪ Crisis Services including training and behavioral programming for prevention ▪ Behavior issue prevention ▪ Translation services ▪ Supportive services including family education, a resource center, ▪ Supportive employment including follow along services ▪ Improved communication and collaboration

Committee Focus Groups (January - March 2008)			
Committee	Date	Number of Participants	Gaps Identified
			▪ Better access (hours, services, language) ▪ Quality including workforce development ▪ More integrated services for dually diagnosed consumers ▪ More psychologists that accept Medicaid ▪ A continuum of supports including a step down from Case Management
Substance Abuse Prevention Committee (MCSPAC)	2/21/08	5	▪ Latino Services ▪ Criminal Justice Services ▪ Adult Services ▪ Culturally sensitive (African-American) services ▪ Teen centers and programs ▪ Wellness marketing
CFAC	2/28/08	14	▪ More quality data ▪ Workforce development and quality, particularly community support ▪ Supportive employment ▪ Crisis training ▪ PCP quality ▪ Brokerage of services ▪ Prioritization ▪ Senior services ▪ Services to active and veteran military
Planning and Collaboration Committee	2/28/08	16	▪ Improved communication ▪ Prevention ▪ Quality (staff, PCP preparation, accountability) ▪ Cultural competence ▪ Need for more quality data
Steering Committee	2/28/08	6	▪ Competence ▪ Communication, collaboration, cooperation ▪ Best practices

Interviews

Interviewee	Issues
Individual interview with the Program Director of regional deaf and hard of hearing services:	▪ Adolescent inpatient services ▪ Substance abuse services ▪ Psychosocial rehabilitation ▪ Day services ▪ Wraparound services ▪ Residential services
Individual interview with the Director of a provider representative from the North Mecklenburg region.	▪ Psychiatric services, particularly child ▪ Substance abuse services, inpatient and outpatient ▪ Detox ▪ Spanish-language services ▪ Spanish-language 12-step programs ▪ School-based services ▪ No formal needs assessment of North Mecklenburg region

Provider Surveys

All providers were invited to complete an electronic survey. The survey consisted of 22 questions divided among general service needs, gaps, and capacity and specific needs, gaps and capacity within four service areas, Developmental Disabilities, Mental Health, Substance Abuse, and Child and Adolescent Services. Mecklenburg received 123 provider survey responses.

	Providers	Community & Stakeholders	Provider CEO
Number of Responses	123	160	44

Important Information for Interpreting Survey Results

Every effort was made to create surveys instruments that were valid in providing the kinds of information needed, reliable in that most respondents would understand the questions in the same way, appropriately easy to understand and complete, and using language most accessible to potential respondents. However, because these instruments were specifically designed for this needs assessment and had not been used before, some problems arose that will be corrected in subsequent surveys.

Consequently, it is important to understand the following while interpreting survey results:

"Don't Know" Answers:
The "don't know" option was intended to offer respondents a way to say they genuinely did not know the response to a specific question. However, the high percentage of "don't know" responses is some cause for concern.

Further analysis was performed to help glean more information from "don't know" responses; this was essentially a test-run to see if more useful information could be gathered. Surveys were sorted by all those who said they provide developmental disability services. Review and analysis of the "don't know" responses related to all developmental disability services were then performed on this subset of surveys in hopes there would be significantly fewer "don't knows." This was not the case, however. Virtually the same number and percentage of "don't know" responses appeared even when those delivering service to one disability area responded only to questions related to that disability area.

Possible "Don't Know" Interpretation and Next Steps:

- First and foremost, the high number of "don't know" responses suggest a need for extensive education, particularly among providers, regarding the types of services available to consumers.
- Additional reviews of narrative comments might also reveal more information about the degree to which consumers, families, providers, and stakeholders know about additional services.
- When repeating this survey it may be valuable to add a "not applicable" column in addition to "don't know" in order to separate these responses.

Understanding Survey Results:

Several efforts were made to sort and prioritize survey results, including efforts to highlight areas of significance. Most notable, the consultants reviewed answers to each survey question individually in conjunction with narrative comments and forum data in order to identify areas that may warrant prioritization or further investigation. While this effort did yield some highlighted priorities question by question, it was impossible to define a standard threshold level of acceptable results across questions or across the whole survey itself. More importantly, it was difficult for the consultants to determine level of acceptable performance out of context with direction from the Mecklenburg LME leadership and best practice committees.

Consequently, this report, including survey results, should be understood as a vast collection of important, preliminary data that will contribute to a variety of next-tier review and analysis. Mecklenburg LME will give this report and data to each best practice committee for their thorough review and analysis. Each committee is encouraged to study these preliminary results and determine its own criteria and methodology for further analysis and prioritization.

General Service Needs

Providers identified the following general service needs based on survey questions 3 – 9:

- Developmental disabilities services for youth
- Substance abuse services for adolescents
- Services for customers with co-occurring treatment needs
- Evening and weekend treatment options, particularly for substance abuse and for youth with varying needs (questions 4 & 5)
- Improved service for various cultural, linguistic and unique diversities.

The survey asked:

3. Can the consumers you serve receive the following general services in your community?						
Answer Options	% Responding					
	Always	Usually	Sometimes	Seldom	Never	Do Not Know
Developmental disabilities services for adults	23.9%	37.3%	11.9%	3.0%	3.0%	20.9%
Developmental disabilities services for children	19.0%	25.4%	7.9%	4.8%	3.2%	39.7%
Mental health services for adults	43.8%	34.2%	16.4%	1.4%	1.4%	2.7%
Mental health services for children	33.3%	23.2%	14.5%	1.4%	1.4%	26.1%
Substance abuse services for adults	36.9%	29.2%	10.8%	6.2%	1.5%	15.4%
Substance abuse services for adolescents	10.0%	21.7%	23.3%	10.0%	1.7%	33.3%
Integrated mental health and substance abuse services for adults	15.9%	33.3%	21.7%	8.7%	5.8%	14.5%
Integrated mental health and substance abuse services for youth	6.1%	18.2%	21.2%	12.1%	4.5%	37.9%
Integrated mental health and developmental disabilities services for adults	14.1%	18.8%	17.2%	7.8%	9.4%	32.8%
Integrated mental health and developmental disabilities services for youth	6.6%	16.4%	11.5%	9.8%	8.2%	47.5%
Integrated developmental disabilities and substance abuse services for adults	9.1%	14.5%	14.5%	10.9%	5.5%	45.5%
Integrated developmental disabilities and substance abuse services for youth	3.7%	7.4%	7.4%	11.1%	3.7%	66.7%
Integrated mental health, developmental disabilities, and substance abuse services for adults	10.3%	17.2%	15.5%	12.1%	6.9%	37.9%
Integrated mental health, developmental disabilities, and substance abuse services for youth	7.1%	12.5%	7.1%	8.9%	7.1%	57.1%
Percent calculations based on response rate per row.						

Twenty-five respondents (20.3%) contributed to the following question:

8. Please describe in detail the services your consumers need but are unable to receive due to culture, language or other unique demographic diversity.

Among the responses were:

- Asian clients have difficulty because there is not staff, translators or program in their language (3); Hmong, Lao, Thai, Cambodians, Vietnamese, and Chinese.
- Intensive In-Home providers who can serve non-English speaking families (3)

- More bi-lingual workers who speak both Spanish and English (3)
- Difficult with limited funding for staff to provide separate services for someone who needs a translator...to participate in main group with a translator is too disrupting to the group (2)
- Many services do not have interpreters on staff and therefore discriminate against the deaf population (2); For deaf and other hearing loss populations, there are NO mental health psychosocial rehabilitation services, wraparound services, comprehensive Substance abuse, inpatient programs for adolescents in mental health or substance abuse programs that are fluent in ASL or familiar/ willing to work with interpreters.
- Our consumers need psychiatric inpatient services.
- Undocumented people have become afraid to seek services due to fear of deportation
- Adults for Community Support services are reluctant to participate in services due to what they describe as a lack of trust for the system.
- Therapeutic Foster Care can be difficult to provide to a child who speaks a different language. Spanish-speaking TFC parents have been located but no other languages.
- I have 1 consumer who speaks both Spanish and English. I have not had barriers to service with this experience.
- Affordable housing for adults with disabilities that have children.
- One provider has catered to the demographic needs of the community by hiring a large percentage of bilingual staff in efforts of providing appropriate services.
- African Americans have a unique cultural and other demographic diversity and are sometimes unable to receive adequate services because of the culture difference.

Developmental Disability Services

Providers were split on whether there are unmet developmental disability service needs in their area, with 16 percent responding "yes" and 17.3 percent responding "no" and a 66.7 percent majority responding "do not know." Respondents were also asked to:

10. Please rate the availability of the following developmental disability services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Screening/Assessment	44.2%	1.3%	11.7%	1.3%	2.6%	40.3%
Crisis Services	44.7%	2.6%	5.3%	3.9%	2.6%	42.1%
Targeted Case Management	41.3%	2.7%	13.3%	1.3%	2.7%	41.3%
Community Rehabilitation	26.8%	7.0%	4.2%	0.0%	2.8%	62.0%
Supported Employment	27.0%	2.7%	14.9%	4.1%	2.7%	50.0%
Supported Employment Follow-along	21.1%	2.8%	12.7%	4.2%	2.8%	56.3%
Day Activity	36.0%	1.3%	8.0%	8.0%	2.7%	45.3%
Residential Services	32.9%	2.6%	15.8%	3.9%	2.6%	42.1%
Developmental Therapy	22.2%	1.4%	13.9%	6.9%	2.8%	52.8%
Personal Assistance	27.4%	0.0%	15.1%	2.7%	2.7%	52.1%
Respite	28.0%	1.3%	13.3%	4.0%	2.7%	50.7%
Community Activities and Employment Transition	25.7%	1.4%	13.5%	2.7%	2.7%	54.1%

10. Please rate the availability of the following developmental disability services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Home and Community Support	39.5%	1.3%	9.2%	1.3%	2.6%	46.1%
Residential Supports	33.3%	1.3%	14.7%	2.7%	2.7%	46.7%
Personal Care Services	36.1%	1.4%	6.9%	1.4%	2.8%	51.4%
Augmentative Communication Devices	17.1%	0.0%	5.7%	0.0%	2.9%	74.3%
Day Supports	32.9%	2.7%	4.1%	1.4%	2.7%	58.9%
Home Modifications	18.6%	1.4%	10.0%	1.4%	2.9%	65.7%
Individual Caregiver Training and Education	24.3%	1.4%	4.3%	1.4%	2.9%	65.7%
Specialized Consultative Service	15.7%	1.4%	4.3%	1.4%	2.9%	74.3%
Specialized Equipment and Supplies	20.3%	1.4%	2.9%	1.4%	2.9%	71.0%
Vehicle Adaptations	14.7%	1.5%	8.8%	2.9%	2.9%	69.1%

Percent calculations based on response rate per row.

Sixteen respondents (13%) contributed to the following question:

12. Please describe the developmental disability services that are not available that your consumers need.

- Developmental Therapy, Personal Assistance (5);
  - More Developmental Therapy services would be of benefit. Currently PA seems to have more goal work than is merited by the reimbursement rate. Staff are asked to do community-type activities and have lower reimbursement than what supports the service.
  - Adequate funding for DT & PA
  - Until recently DT and PA had long waitlists. The LME has taken steps to address this issue. Some consumers will need one on one support at the worksite to be successful with employment. Although this is changing, many individuals with more sever disabilities are not getting the support they need to explore employment options.
  - If a person does not have CAP services it is very unlikely that they would receive any other service due to contract restraints. All of the services are available to those who have qualified for the CAP waiver. Developmental Therapies is a joke - who gets this service - everyone says that they do not have the money for it - so why is it listed on paper.
- Housing/living situation (2); Affordable housing for consumers that have children
- Difficult to transition consumer from one service area, such as Adult Mental Health, to DD services
- Psychiatric inpatient care for dually diagnosed individuals that are a danger to themselves or others. They are not admitted to MH, but sent home
- Services designed for people with Traumatic Brain Injuries
- More appropriate day services for consumers. Guardians are complaining that current services are not meeting the needs.
- Community based training to increase level of independence from family.
- Services specifically tailored to the needs of individuals on the autism spectrum--- such as Asperger's Syndrome

- Limited space for deaf and hearing loss consumers in programs with sign-language fluent staff
- Easier access to the Watkins Center for medication management, more appropriate targeted case management

Mental Health Services

Half of providers stated there are unmet mental health service needs in their area, with only 15.6 percent reporting that there are no needs that cannot be met in their area. Respondents were also asked to:

13. Please rate the availability of the following mental health services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Mobile Crisis Management	66.7%	1.4%	5.6%	4.2%	1.4%	22.2%
Diagnostic / Assessment	61.8%	3.9%	19.7%	3.9%	0.0%	10.5%
Community-Based Inpatient Psychiatric Treatment	54.7%	2.7%	21.3%	8.0%	0.0%	17.3%
Community Support	72.4%	3.9%	14.5%	0.0%	0.0%	10.5%
Community Support Team	60.3%	5.5%	11.0%	1.4%	0.0%	21.9%
Psychosocial Rehabilitation	45.1%	4.2%	19.7%	4.2%	0.0%	28.2%
Partial Hospitalization	47.9%	2.7%	26.0%	2.7%	1.4%	20.5%
Psychiatric / Medication evaluation & management	47.9%	7.0%	33.8%	1.4%	0.0%	12.7%
Therapy or Counseling (individual, interactive, group, family)	52.6%	10.5%	27.6%	1.3%	0.0%	10.5%
Assertive Community Treatment Team (ACTT)	35.7%	2.9%	17.1%	5.7%	0.0%	38.6%
Facility Based Crisis Services	48.6%	2.9%	8.6%	7.1%	0.0%	32.9%
Supported Employment	32.9%	1.4%	14.3%	2.9%	0.0%	48.6%
Supported Employment Follow-along	30.0%	1.4%	12.9%	2.9%	0.0%	52.9%
Residential Services	46.6%	2.7%	34.2%	4.1%	0.0%	12.3%
Peer Support	37.1%	1.4%	10.0%	5.7%	0.0%	45.7%

Percent calculations based on response rate per row.

Twenty-three respondents (19%) contributed to the following question with clear consensus on gaps:

15. Please describe the mental health services that are not available that your consumers need.

- Wait times & hours of operation (4):

    - Consumer's need to be able to be seen more readily than is occurring in the community. Sometimes the wait is too long and many people get frustrated and/or slip through the cracks until the next crisis.
    - More options for medication management-- med clinic has LONG waiting for consumers
    - Services may be available, but they are difficult to access
    - More after hours activities and treatment options.
- Housing shelters (3):
    - Housing and community support specifically for the homeless population
    - Housing is an issue for the adults that we are serving - Felons with mental health issues
- Supported Employment (3):
    - Supported Employment takes forever to access
    - Supported employment that utilizes training, education and individualized placement in jobs
    - Need more effective job search assistance
- Crisis services (3), crisis center, crisis services and placement for JSO
- Community-Based Inpatient Psychiatric Treatment (2)
- Psychosocial Rehab - Waiting list is unbelievable for adults
- Counseling and therapy in the Mecklenburg area is not an issue - could use more groups
- Our consumers are all deaf, hard of hearing, late-deafened, and deaf-blind. The following services are not available with sign-language fluent staff or familiarity/ willingness to provide interpreters as they would a hearing client: community-based or local inpatient services for adults and adolescents, wraparound services for mental health and substance abuse, residential services, day programs for mental health and/or substance abuse. Our agency will soon cease to provide community support services. Thus, CSS services for this population are also needed.
- More access to residential treatment and residential substance abuse facilities [dual diagnosed].
- ACTT team is full but VO is continuing to deny services with the recommendation to refer to ACTT team.
- We need more residentially based mental health services locally. Also, wait times at are way too long, sometimes 6-8 weeks
- Limited case management for people who need some assistance but don't meet criteria for community support.
- Increased transportation services
- Qualified therapists
- Need more day program options
- The dilution of CS providers created more "bad" apple options. Families have more choice, but a lot of the choices are like picking an apple with a worm in it.
- ER-crisis services/assessments/safe areas for temporary stabilization/case management!!!
- Resource center
- Psycho-education programs based on best practices
- More peer services
- Training and education programs for consumers, ran by consumers
- More PSR options
- Increased options for individual and group therapy, especially for specialized treatments such as DBT and CBT

Substance Abuse Services

Fifty-one percent of providers did not know if there were unmet substance abuse service needs in their area; 30 percent stated there are no unmet needs, and 19 percent report that there are unmet needs that cannot be met in their area. Respondents were also asked to:

16. Please rate the availability of the following substance abuse services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Inpatient Hospital Substance Abuse Treatment	30.1%	1.4%	28.8%	9.6%	4.1%	27.4%
Intensive Outpatient Treatment	48.6%	5.4%	17.6%	1.4%	4.1%	24.3%
Comprehensive Outpatient Treatment (particularly for adults with children)	34.2%	4.1%	13.7%	4.1%	4.1%	41.1%
Non-Medical Community Residential Treatment	24.6%	0.0%	24.6%	2.9%	4.3%	44.9%
Medically Monitored Community Residential Treatment	23.2%	0.0%	21.7%	4.3%	4.3%	46.4%
Halfway House	27.5%	0.0%	27.5%	2.9%	4.3%	37.7%
Detoxification Treatment	50.0%	2.8%	12.5%	2.8%	4.2%	27.8%
Prevention Activities	40.0%	1.4%	8.6%	4.3%	5.7%	40.0%
Peer Support	35.7%	2.9%	8.6%	5.7%	4.3%	42.9%

Percent calculations based on response rate per row.

Fifteen respondents (12%) contributed to the following question:

18. Please describe the substance abuse services that are not available that your consumers need.

- Residential/Detox/Halfway House beds (10)
  - Current facilities are often at capacity
  - Residential (3-12 months) beds
  - Half-way house services are far too limited

    - There is one concern that we have experienced at one time - the inability to enter into a residential program immediately. We were told that detox was full
    - More availability of transitional housing which has such a long waiting list
    - Housing-shelters (allowances - 'wet' and 'dry')
    - We need SA specific residential services. Based on the volume in the SA community we do not have the resources needed for housing. We also need more options for housing-more faith based, more halfway houses, more permanent housing. We also need to look at some harm reduction options like "Wet Houses". We need for agencies to be more willing to work together and share information more readily. We need agencies to have a greater understanding of the admission process and criteria required for different levels of care-this has often delayed the consumer's being admitted as expeditiously as they could have been because agencies having to go back and forth to get appropriate information.
    - Detox beds. Current facilities are often at capacity
    - More beds available for DETOX
- We need more inpatient beds (2)
    - Accessibility to inpatient treatment
    - Current facilities are often at capacity
- While services are available, they are often difficult to get into because of waiting lists or complications due to co-occurring SPMI diagnoses, symptoms, behaviors.
- SACOT that is not directly tied to the homeless shelters
- Child care for women in treatment
- Transportation to and from treatment
- My answers indicate that I do not know however, should the issue arise where my client needed to access these services, I am sure they are located somewhere in Mecklenburg County.
- ER-crisis services/assessments/safe areas for temporary stabilization/case management!!!/
- It would be nice to have AMH sponsored "after hours" activities and transportation assistance for these activities. Many times SA consumer's lack the skills to engage in constructive activities during and after treatment.
- We need more dual diagnosis 12 step programming in the community.
- We need more SA specific community support workers and teams as well as more people available for SA crises.
- The ability to expand the number of employees to serve better the growing number of consumers coming into detox and other programs.
- After twenty-years of provider talking about child care being a barrier to treatment in 2008, it is still a barrier to treatment. We say that addiction is a disease but for women you have children their disease can not be treated because if they have to go into treatment they have no one to care for their children. This remains a problems and it appears that no one is working on a solution to the problem.
- This area of need is especially resistant to serving the deaf due to perceived hardship in hiring interpreters for meetings and treatment especially inpatient, residential, and outpatient services. Our clients have reported being flatly told "I'm sorry, there are no SA services for the deaf"

Child and Adolescent Services

Fifty-four percent of providers did not know if there were unmet child and adolescent service needs in their area; 25 percent stated there are no unmet needs, and 20 percent report that there are unmet needs that cannot be met in their area. Respondents were also asked to:

19. Please rate the availability of the following child and adolescent services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Community Support	44.6%	4.1%	10.8%	0.0%	1.4%	40.5%
Intensive In-Home Services	30.6%	2.8%	11.1%	2.8%	0.0%	52.8%
Multisystemic Therapy	28.2%	1.4%	12.7%	5.6%	1.4%	50.7%
Sex Offender Treatment	22.5%	2.8%	7.0%	11.3%	1.4%	56.3%
Day Treatment	33.8%	0.0%	14.1%	2.8%	1.4%	47.9%
Therapy or Counseling (individual, interactive, group, family)	48.6%	2.9%	7.1%	1.4%	0.0%	40.0%
Psychiatric/Medication Evaluation and Management	36.6%	4.2%	15.5%	1.4%	0.0%	42.3%
Partial Hospitalization	28.2%	1.4%	16.9%	4.2%	0.0%	49.3%
Substance Abuse Intensive Outpatient	28.2%	1.4%	9.9%	7.0%	1.4%	53.5%
Residential Treatment Level II (family setting)	31.4%	1.4%	10.0%	7.1%	0.0%	50.0%
Residential Treatment Level III	29.0%	1.4%	10.1%	7.2%	0.0%	52.2%

Percent calculations based on response rate per row.

Sixteen respondents answered the following question, with another 13 respondents commenting on youth services while answering other survey questions. Those responses are all reflected below as well. Respondents reinforced the gaps identified above, calling for more group homes and other housing support and substance abuse treatment. Respondents also called for after-school care and transitional services for young adults.

21. Please describe the child and adolescent services that are not available that your consumers need.

- More residential settings such as group homes (9)Substance Abuse treatment for youth (4)
  - More outpatient and inpatient services for adolescent substance abusers
  - Substance abuse day TX programs

    - Decent substance abuse services provided by the county for adolescents
    - More day treatment programs for adolescents
- Transitional services for youth into adulthood (4)
    - Mental health services for young adults.
    - We need more transitional services for 17.5 to 20 age group
    - Youth In Transition services. Young adults do not know how to navigate the system and where to access help, especially when they have no support at home. Lack of insurance and money are serious barriers to them getting the help they need and not decomping.
- After-school programs (4)
    - Families need after school services and summer day sites for their children with developmental disabilities.
    - After-school care for adolescents who require heavier supervision.
    - After-school programs with youth with mental health DX
    - After-school care for children and adolescents with mental health needs that attend public school.
- Developmental therapy for children (3)
    - With all of the changes coming forth - no developmental therapies for children - we should implement family education on how to have the needs of the child consumer met when school is not in session
- Sex Offender Treatment Level II Family Setting (2)
    - Community Support is not authorized in a timely fashion. Working with youth who are sexually aggressive and being unable to have community support for them places a major deficit in the availability for these children to be able to attend school.
- More community respite, crisis respite (2)
- More emergency placement
- For youth PRTF, Level IV
- Not enough IIH for Spanish speaking family or younger children (under 10), Therapeutic Foster Care is available but not enough quality workers available (I have a consumer that moved 5 times in 9 months period).
- Qualified therapists
- More intensive in-home services
- Sadly, there are few comprehensive services in the area for children and teens. There is a huge need for these services to prevent future and worst issues and traumas
- Groups for counseling - without having to go to behavioral health
- More MST should be offered
- Services are difficult to access

Community & Stakeholder Surveys

Community stakeholders were invited to complete an electronic survey regarding service needs, gaps, and provider capacity. Mecklenburg received 160 community/stakeholder survey responses. Nearly 40 of respondents represent non-profit agencies, 28 percent represent LME staff; DSS and advocacy organizations represent 11 percent each. Others respondents include public health, community support agencies, consumers, families and other organizations. The survey consisted of 21 questions divided among general service needs, gaps, and capacity and specific needs, gaps and capacity within four service areas, Developmental Disabilities, Mental Health, Substance Abuse, and Child and Adolescent Services. The complete survey is available in the appendix.

1. What type of organization do you represent?

Answer Options	Response Percent	Response Count
DSS	10.8%	16
Hospital	2.0%	3
Public School	0.7%	1
Advocacy Organization	10.8%	16
Juvenile Justice	1.4%	2
Criminal Justice	0.7%	1
Non-Profit Agency	39%	58
Church or Other Religious Organization	0.7%	1
Public Health	4.1%	6
LME Board	0.0%	0
LME Staff	25.7%	38
Consumer	7.4%	11
Family	5.4%	8
Mental Health Provider	3.4%	5
Community Support Provider/Program	3.4%	5
Other (please specify)		2
Answered Question		148

General Service Needs

Community & stakeholders identified the following general service needs:

- Substance abuse service services for youth (survey q. 3 – 5)
- Substance abuse service hours availability (survey q. 4)
- After business hours service needs in general. (survey q. 4 & 5)
- Services for customers with co-occurring treatment needs (survey q. 3 & 7)
- Bi-lingual and culturally sensitive services, across many languages and cultures.(survey q. 6-8)
- Communication of available services (survey q. 3, 5, 8)

3. Can the consumers you serve receive the following general services in your community?						
Answer Options	% Responding					
	Always	Usually	Sometimes	Seldom	Never	Do Not Know
Developmental disabilities services for adults	16.5%	20.9%	19.8%	11.0%	5.5%	26.4%
Developmental disabilities services for children	12.2%	23.3%	22.2%	7.8%	12.2%	22.2%
Mental health services for adults	34.1%	34.1%	15.9%	1.1%	3.4%	11.4%
Mental health services for children	23.6%	31.5%	18.0%	4.5%	9.0%	13.5%
Substance abuse services for adults	26.4%	34.5%	12.6%	4.6%	3.4%	18.4%
Substance abuse services for adolescents	15.7%	22.5%	22.5%	15.7%	9.0%	14.6%
Integrated mental health and substance abuse services for adults	14.6%	21.3%	27.0%	10.1%	3.4%	23.6%
Integrated mental health and substance abuse services for youth	12.2%	15.6%	16.7%	20.0%	12.2%	23.3%
Integrated mental health and developmental disabilities services for adults	11.4%	19.3%	18.2%	11.4%	10.2%	29.5%
Integrated mental health and developmental disabilities services for youth	8.0%	12.5%	19.3%	18.2%	17.0%	25.0%
Integrated developmental disabilities and substance abuse services for adults	9.2%	14.9%	11.5%	12.6%	16.1%	35.6%
Integrated developmental disabilities and substance abuse services for youth	8.0%	12.5%	10.2%	18.2%	22.7%	28.4%
Integrated mental health, developmental disabilities, and substance abuse services for adults	9.0%	18.0%	18.0%	10.1%	13.5%	31.5%
Integrated mental health, developmental disabilities, and substance abuse services for youth	8.0%	12.5%	11.4%	13.6%	25.0%	29.5%
Percent calculations based on response rate per row.						

Twenty-one respondents (13%) contributed to the following:

5. Please describe any hours of operation deficiencies.

- Thirteen responded that more services were needed after 5 p.m. and/or on weekends.
- Two talked about the need for more child support services in the school system.
    - Schools don't seem to want agencies to come in classrooms even if the student and teacher need help.
    - I really like it when students can receive the services while in school because parents do not always follow through to take the child to the appointment.

Thirty respondents (19%) contributed to the following question:

8. Please describe in detail the services your consumers need but are unable to receive due to culture, language or other unique demographic diversity.

- General Language & Cultural Diversity Barriers (17):
  - Was very difficult to find mental health services during after hours, consumer would disrupt placement at odd hours of the night and would constantly awol. SW would often have barriers understanding the language spoken when speaking to parents.
  - Bi-lingual foster therapeutic placements
  - United States citizenship (2); undocumented cannot receive services
  - Services are not available to suite the linguistic needs of consumers who's can not read, write or speak fluent English. There are also cultural issues that arise because the workers they receive due not understand their family traditions, thoughts or methods to managing their health. Also, some of these services are not currently accessible in our county (integrated services) and if they are, there are far and few that provide this service.
  - If they can't get an interpreter they can't effectively communicate to receive services, understand them or complete applications.
  - Brochures in different languages or agencies that deal with different cultures
  - Services for "special populations" in general are lacking. These include bi-lingual services, programs specifically for elderly or youth transitioning from youth to adulthood
  - More recreational options for clients who have problems with the coping skills.
  - Just basic, first level services without having to go through a zillion loops and phone calls to find an interpreter.
  - Interpreters are available but are expensive and create a barrier in regards to the therapeutic process. Community needs more bi-lingual and bi-cultural therapist. There should also be additional funding when interpreters are needed
  - Services for DD population is unavailable and case management services is difficult to receive as well as service are unavailable due to the extremely long wait list
  - Education and awareness of need for resource.
  - Ability to access in their language. Often need to understand English or Spanish to get through telephone prompts to talk to live person.
  - Difficulty in getting interpreter for visit. Sometimes language isn't available or agency isn't willing to offer.
  - They need mental health and substance abuse services. Culturally, many are fearful of anyone knowing anything about them and are fearful of any goverment related organization. They do have the money to self pay and are not eligible for Medicaid. Transportation is such an issue to get to services even if they were inclined. The biggest issue is convincing them to seek help.
  - Quality Mental Health services
  - There really isn't anything available for those OTHER THAN Spanish speaking people
- Latino Barriers (4):
  - MH counseling for Spanish speaking folks
  - We are finding a number of Latin consumers that are in need of dwi assessments, treatment for alcoholism and substance abuse are finding it difficult to find services near their neighborhoods.
  - Our clients need residential, inpatient, dual diagnosis services at times, but these services are not readily available in Spanish. The nearest inpatient facility is two hours away and self-pay, which discourages substance abuse clients who need the services. Also, we have gotten adolescents who need substance abuse services, but there is no substance abuse treatment program in Spanish for adolescents, forcing our agency to either take the adolescents, or refer them to an English program.
  - Cultural competence of our providers are not keeping stride with the growing diversity of the community. There are scant Spanish speaking providers for therapy or substance abuse issues which are a major need in our community.

- Asian Barriers (3):
  - Finding a Hmong interpreter is almost impossible.
  - Parenting education/substance abuse services for Asian families.
  - Montagnards (Vietnam) not using transit system and unable to access medicaid transportation due to language barrier.
- No problems (5)
- Veterans:
  - Returning veterans have Tri-Care insurance and there are only a few MH therapists in the community who take Tri-care for outpatient therapy. There are no SA providers for Tri-care-- which is a big issue. Also, they do not qualify for VA benefits yet-- so they cannot go to Salisbury to the VA for services because they often need to get their medical records and complete discharge in place before they get VA benefits. Technically, these consumers are stuck because they have benefits (technically) and do not qualify for IPRS funding and yet there are no providers in the area who take their insurance (particularly SA) -- so it's very frustrating for them.
- Native American:
  - There aren't direct care staff who speak these languages or are familiar with the culture.

General comments throughout the survey support the need for bi-lingual services and increased access to substance abuse services and services for consumers with co-occurring treatment needs.

Developmental Disability Services

When then asked whether there are unmet developmental disability service needs in their area 64 percent responded “do not know;” 21.3 percent responded “yes” and 14.7 percent responded “no.” Asked to rate the availability of listed developmental disability services in their area, the majority of respondents in almost every category responded “do not know.” The only exceptions were Screening Assessment, Crisis Services, Home and Community Support and Targeted Case Management.

9. Please rate the availability of the following developmental disability services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Screening/Assessment	44.4%	8.3%	13.9%	1.4%	0.0%	33.3%
Crisis Services	42.3%	4.2%	9.9%	8.5%	0.0%	36.6%
Targeted Case Management	40.3%	9.7%	13.9%	1.4%	0.0%	36.1%
Community Rehabilitation	31.4%	5.7%	8.6%	4.3%	0.0%	51.4%
Supported Employment	29.6%	1.4%	14.1%	8.5%	0.0%	49.3%
Supported Employment Follow-along	16.7%	1.4%	12.5%	9.7%	0.0%	62.5%
Day Activity	29.2%	1.4%	11.1%	8.3%	0.0%	51.4%

9. Please rate the availability of the following developmental disability services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Residential Services	27.1%	0.0%	28.6%	7.1%	0.0%	41.4%
Developmental Therapy	19.4%	6.9%	12.5%	6.9%	0.0%	55.6%
Personal Assistance	20.8%	4.2%	11.1%	6.9%	0.0%	58.3%
Respite	37.1%	1.4%	11.4%	8.6%	0.0%	44.3%
Community Activities and Employment Transition	22.1%	2.9%	11.8%	8.8%	0.0%	55.9%
Home and Community Support	40.8%	1.4%	15.5%	5.6%	0.0%	38.0%
Residential Supports	30.6%	1.4%	13.9%	11.1%	0.0%	45.8%
Personal Care Services	23.9%	2.8%	8.5%	8.5%	0.0%	57.7%
Augmentative Communication Devices	20.0%	1.4%	10.0%	2.9%	0.0%	67.1%
Day Supports	26.0%	1.4%	8.2%	12.3%	0.0%	53.4%
Home Modifications	18.3%	1.4%	7.0%	8.5%	0.0%	66.2%
Individual Caregiver Training and Education	20.8%	2.8%	11.1%	5.6%	0.0%	61.1%
Specialized Consultative Service	18.1%	2.8%	5.6%	4.2%	1.4%	68.1%
Specialized Equipment and Supplies	18.1%	2.8%	8.3%	4.2%	1.4%	66.7%
Vehicle Adaptations	14.1%	2.8%	7.0%	4.2%	0.0%	73.2%

Percent calculations based on response rate per row.

Eighteen respondents (11%) contributed to the following question:

11. Please describe the developmental disability services that are not available that your consumers need.

- Employment (4):
  - More job placements for adults
  - Useful supported employment programs
  - Consistent, high quality supported employment
  - More work with vocational pursuits
- Crisis, substance abuse, mental health
- Services need to be implemented a lot more quickly not hours later. When consumers are in crisis the need services promptly. One provider has a history of keeping consumers and SW in waiting areas for several hours. My longest wait was for 7-1/2 hours one evening after the ER was made aware that this consumer was on their way after a long day traveling from another county three hours away.
- More choices of agencies for Case Management. Many current agencies have too high of turnover and services get dropped and delayed in between Case Managers. They need agencies that focus more on retention of staff than making a lot of money by having caseloads too high to manage effectively.
- Psychosocial, counseling, behaviorist all with expertise in DD

- The program I work with, Adult Homeless MI is sometimes the default program for persons who can not meet all the rigid documentation requirements for developmental problems. This is the case particularly for pervasive developmental disorder. Consumer on the streets with lack of supports and the community considers this a mental health problem.
- Integrated dual diagnosis supports and better crisis supports
- Residential alternatives
- Flexible transportation
- Day supports. Since the removal of day programs for DD consumers, many have nothing to do during the day if they are too low functioning to work.

Mental Health Services

When then asked whether there are any unmet mental health service needs in their area 38 percent responded "yes;" 30 percent responded "no" and 32 percent responded "do not know."

12. Please rate the availability of the following mental health services in your area:

Answer Options	% Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Mobile Crisis Management	60.6%	9.1%	6.1%	9.1%	1.5%	15.2%
Diagnostic / Assessment	56.7%	9.0%	28.4%	4.5%	0.0%	4.5%
Community-Based Inpatient Psychiatric Treatment	48.5%	7.6%	24.2%	4.5%	1.5%	15.2%
Community Support	64.2%	1.5%	23.9%	4.5%	0.0%	7.5%
Community Support Team	55.9%	5.9%	17.6%	7.4%	0.0%	16.2%
Psychosocial Rehabilitation	43.5%	8.1%	19.4%	3.2%	1.6%	29.0%
Partial Hospitalization	44.6%	4.6%	26.2%	3.1%	1.5%	21.5%
Psychiatric / Medication evaluation & management	44.8%	6.0%	34.3%	1.5%	1.5%	14.9%
Therapy or Counseling (individual, interactive, group, family)	51.5%	7.6%	30.3%	1.5%	0.0%	12.1%
Assertive Community Treatment Team (ACTT)	40.3%	3.0%	10.4%	7.5%	0.0%	40.3%
Facility Based Crisis Services	39.4%	1.5%	15.2%	18.2%	0.0%	27.3%
Supported Employment	26.2%	4.6%	16.9%	10.8%	1.5%	44.6%
Supported Employment Follow-along	22.4%	4.5%	14.9%	10.4%	1.5%	49.3%
Residential Services	33.8%	4.4%	30.9%	11.8%	0.0%	22.1%
Peer Support	34.3%	4.5%	9.0%	10.4%	0.0%	43.3%

Percent calculations based on response rate per row.

Twenty four respondents (15%) contributed to the following question:

14. Please describe the mental health services that are not available that your consumers need.

- Residential Services/Facilities/Supported Housing options (8):
    - Residential services are not available at Level 4
    - Secured adult residential
    - Safe Havens housing for homeless mentally ill
    - Housing for people who are homelessness
- More vocational pursuits (4):
    - Need more day program options
    - Need more effective job search assistance
    - High quality, stable work force to provide the services, especially community support and supported employment supported employment in which there is job creation, placement and training for consumers; a resource center where there are opportunities for education, groups, access to services, referrals to services
    - Supported Employment has a long waiting list as well
- Wait times (4):
    - More appts for outpt tx-- it takes over a month to get a counseling appt
    - Less then a handful of Community Support Team providers. It seems that some of the many Community Support Individual Providers do not want to lose their consumers even when the need for a more intensive level of service is medically necessary. And, there is only 1 provider for Psych Medication Eval and Management. The consumers typically have to wait in the lobby for 2-6 hours for their scheduled appointment.
    - Level 4 treatment services are not available to this community and the wait for approval and a bed elsewhere takes far too long
    - Service hours have been reduced too much by Value Options for invalid reasons. They need to revise their process or there needs to be an additional service to fill in the gaps.
- Language(2):
    - More mental health individual treatment for Spanish Speaking clients. Use of an interpreter has discouraged and turned away many clients in the past who desperately need services.
    - Resources for adult refugees with language and cultural competency that the refugee can access.
- Another ACT Team (2); only one ACTT provider
- Quality Mental Health Services- QPs, APs, , therapeutic foster care are all lacking in quality.
- The mobile crisis team won't always work with our people -- they decide on the phone if it's a crisis or not and whether they will even come out. If our staff thinks it's a crisis, aren't they supposed to be able to call them for help???
- The mobile crisis team is hampered by "not being able to go to the community without a request or release from the consumer" what is the point?
- More than one PSR clubhouse
- Crisis center
- Consumer run programs
- Suicide recognition and prevention
- Medication management options other than the med clinic
- Transition services from inpatient to community
- Peer services
- Best practices such as wellness management and recovery
- WRAP
- Transportation options
- Better crisis supports and peer supports services.
- Integrated dual diagnosis services

- Additional hospital diversion services
- Alternatives to hospitalization for acute crises
- Based crisis must be determined through an eval from the Psych ER. In the past, a clinician could staff issues with the MD and possibly complete a direct admission. And, there is only 1 provider for PSR.
- Quicker access to consultation to determine if services can be provided
- Very confusing to navigate all of the new private providers.

Substance Abuse Services

When then asked whether there are any unmet substance abuse service needs 48 percent responded "do not know;" 27 percent responded "yes" and 24 percent responded "no." Asked to rate the availability of listed substance services in their area, the majority of respondents in many categories responded "do not know."

15. Please rate the availability of the following substance abuse services in your area:

Answer Options	% of 64 Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Inpatient Hospital Substance Abuse Treatment	31.3%	3.1%	28.1%	7.8%	1.6%	29.7%
Intensive Outpatient Treatment	55.6%	7.9%	12.7%	1.6%	1.6%	22.2%
Comprehensive Outpatient Treatment (particularly for adults with children)	41.3%	3.2%	12.7%	4.8%	1.6%	38.1%
Non-Medical Community Residential Treatment	30.2%	1.6%	12.7%	6.3%	1.6%	50.8%
Medically Monitored Community Residential Treatment	12.7%	1.6%	20.6%	9.5%	1.6%	55.6%
Halfway House	29.0%	0.0%	24.2%	6.5%	1.6%	40.3%
Detoxification Treatment	52.4%	1.6%	14.3%	3.2%	1.6%	28.6%
Prevention Activities	25.0%	3.3%	8.3%	10.0%	1.7%	53.3%
Peer Support	31.7%	1.6%	6.3%	6.3%	1.6%	52.4%

Percent calculations based on response rate per row.

Thirteen respondents (8%) contributed to the following question:

17. Please describe the substance abuse services that are not available that your consumers need.

- Aftercare services
- More transitional housing
- Need a larger detoxification center to be able to handle the need for the entire City/County
- When there are women with children, they cannot access treatment except at the Salvation Army. If they need inpatient treatment, they cannot go because there is no where to place their children (except in DSS custody). This does not make sense.
- Again, language and cultural competency. Need for education and awareness through use of interpreters.
- Latino consumers are in desperate need for more detoxification programs, halfway houses, and residential treatment centers that provide some treatment in Spanish. I think all agencies should move to trying to hire at least one professional who can begin to serve these individuals. If we wait until they begin showing up, it is too late!
- There is not a clearly defined best practice model for integrated dual diagnosis programs. There are some providers who "say" this is what is happening but without a clear definition or guidelines how can we know?
- Integrated services, increased direction towards support groups for community prevention non-service related supports, step oriented housing programs, diagnostic assessments for dual diagnosed consumers, etc...
- Need substance abuse services for people with dual diagnoses - either mental health or developmental disabilities more residential living, without as long of a wait.
- Preventive activities, peer support, hospital substance abuse

Child and Adolescent Services

When then asked whether there are any unmet child and adolescent service needs in their area 57 percent responded “do not know;” 27 percent responded “yes” and 17 percent responded “no.” Asked to rate the availability of listed child and adolescent services in their area, the majority of respondents in nearly every category responded “do not know.”

18. Please rate the availability of the following child and adolescent services in your area:

Answer Options	% of 61 Responding					
	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Community Support	43.3%	0.0%	20.0%	3.3%	0.0%	36.7%
Intensive In-Home Services	35.0%	3.3%	18.3%	3.3%	0.0%	43.3%
Multisystemic Therapy	37.3%	3.4%	11.9%	3.4%	0.0%	45.8%
Sex Offender Treatment	16.9%	1.7%	13.6%	13.6%	1.7%	54.2%
Day Treatment	32.2%	1.7%	16.9%	3.4%	0.0%	49.2%

18. Please rate the availability of the following child and adolescent services in your area:						
	% of 61 Responding					
Answer Options	Available when needed	Available but inconvenient hours	Wait for service/1st appt. too long	Service not available	Service not needed	Do not know
Therapy or Counseling (individual, interactive, group, family)	46.7%	5.0%	15.0%	1.7%	0.0%	35.0%
Psychiatric/Medication Evaluation and Management	38.3%	6.7%	18.3%	1.7%	0.0%	38.3%
Partial Hospitalization	33.9%	0.0%	15.3%	5.1%	1.7%	45.8%
Substance Abuse Intensive Outpatient	25.4%	3.4%	11.9%	8.5%	1.7%	54.2%
Residential Treatment Level II (family setting)	25.9%	1.7%	17.2%	5.2%	0.0%	51.7%
Residential Treatment Level III	21.7%	1.7%	25.0%	3.3%	1.7%	48.3%
Percent calculations based on response rate per row.						

Fourteen respondents (9%) contributed to the question: Please describe the child and adolescent services that are not available that your consumers need. However, several additional respondents commented on youth services while responding to other questions. Their comments are included below as well.

- Dual Diagnosed (6):
  - Services for youth with MH and DD issues are very limited.
  - Dual diagnosis treatment programs
  - Residential programs for dual diagnosis of DD and MH
  - Need integrated dual diagnosis treatment
  - Integrated dual diagnosed services
  - Dual diagnosis day treatment programs
- Sex offender treatment (6) –
  - We have several adolescents that need sex offender treatment
  - Sex offender treatment for serious offenders is non-existent.
  - Sex offender treatment is not easy to find either-- particularly if it is residential-- we have few providers for this specialty.
  - Sexual Offender services could increase
  - Sex offender step down programs/day programs
- Developmentally Disabled (6):
  - Need residential placements for DD children with behavioral/emotional issues
  - Child DD services are extremely hard to locate and utilize. There is not continuous services across ages
  - Currently, there is little if any service available for school age children with DD diagnoses or Autism Diagnoses, who are in desperate need of services. Having recently told that CMS is responsible for the life skills training of school age individuals, the neediest of our population is not eligible for Developmental Therapy service. It is heart rendering to listen to a parent, who wants desperately to

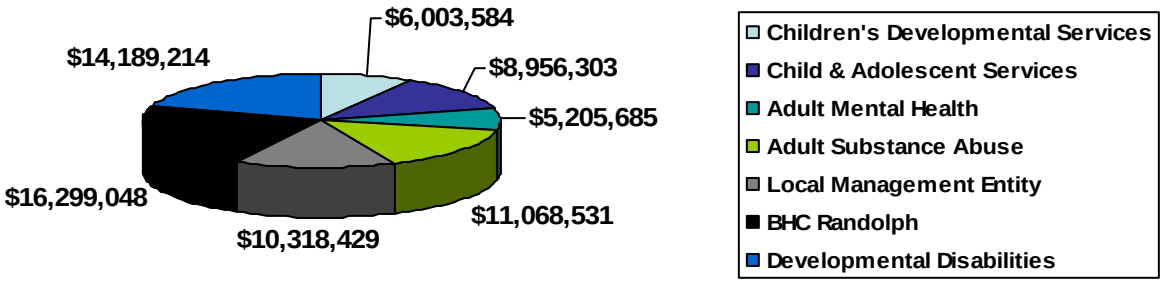
keep their loved one with them in the community, talk about residential placements because they can not get support.
    - Programs specifically for individuals along the autism continuum including Asperger's Syndrome
    - DD therapeutic foster homes, training and education for caregiver/foster parent, autistic assessments and evaluations without the long wait list of two years
    - DD day treatment programs (2)
- Substance abuse treatment/Detox for Adolescents (4)
    - Substance abuse support group or after care program, adolescent NA/AA meetings
- Family support (4); more education for parents; family psychoeducation; services aimed at helping families support their child (not MST)
- Wait times (4):
    - Long wait list for children needing PRTF
    - If consumers cannot gain access to services they need WHEN they need it, it is as though the service does not exist. The same is true for services that are delivered ineffectively.
    - Value Options is making it difficult to keep an appropriate number of hours to support maximum stability.
    - Intensive In-home treatment is difficult to find a provider at times
- Community Support (3)
    - Community support services seem inadequate. It is much too difficult to get funding for these services. Then, youth behaviors escalate, requiring residential intervention.
- CAP (3); There are huge waiting lists for CAP services
- Quality (3):
    - IRTs and quality services
    - There is an overall lack of services for adolescents. The quality of services provided is low and the providers are too few to meet the needs of the children.
    - More resources are needed to meet the needs of the community. Divestiture of case management services was a serious mistake. The quality of providers is low and families have suffered as a result.
- Level III and IV placement (3)
    - Level 2 and 3 placements are scarce, one on one staff for level 3 children minimum waking hours is needed for underplaced children to survive until the appropriate placement is identified and available
    - Level three type children do not receive the 24/7 one on one staff assistance they need to be successful in a foster/community setting.
- Residential support (2)
    - Residential placements for hard to place youth; particularly those who are aggressive and court involved.
- Language and cultural competency (2).
- Services for girls
- Therapy
- Transitional youth services
- Therapeutic groups not hosted at CMC or in Partial Day Hospital, etc...
- Some sort of boot camp that will be beneficial to change. Not just a place to put behavioral kids
- CBS
- Assessment

FY '07 Expenditure and Consumer Count Data

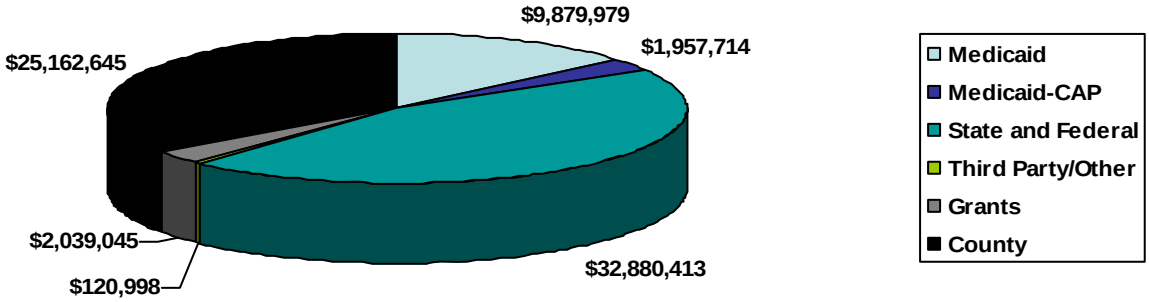
Medicaid and IPRS/County Data

Assessment analysis included gathering and charting Medicaid, IPRS, County and Jail Services expenditures. The following graphs offer summary information.

Service Continuum



Revenue Source



Unearned State Fund Expenditures

For fiscal year FY-'07-'08 Mecklenburg County earned all of its STATE IPRS funds, however there are two categories of the Federal portion of IPRS funds that were not earned: Child Mental Health and PATH. Child MH dollars continue to be difficult to earn during this fiscal year as well due to most children being on Medicaid and under the target population of CMSED (the funds are designated for CMMED). PATH funding is being earned this year as a result of identifying non-billable services as non-UCR, therefore no longer having to earn them through IPRS.

It should also be noted that Mecklenburg County has a blended funding model and integrates State and County dollars in the support of consumers and their Person Centered Plans. While the LME does manage the budgets separately and keeps track of how State vs. County dollars are spent, it is fluid in the context of funding service needs.

Other Data

Progress Indicators Data

According to the Performance Contract, the public system is charged with serving all NC residents who have inadequate personal resources and are in need of specialized MH/DD/SA services. Treated prevalence is calculated by the number of persons in the group served divided by the national prevalence estimate.

Results Published in NC Division Report for October – December 2007:

	Mecklenburg			
Indicator	**MH**	**DD**	**SA**	**State Target**
Individuals in Need of Service	Adult: 22% Child: 28%	Adult: 31% Child: 15%	Adult: 7% Child: 5%	AMH: 38% ADD: 36% ASA: 10% CMH: 38% CDD: 19% CSA: 9%

Timely Initiation & Engagement in Services (2 visits within 14 days)	44%	70%	75%	42%

	Mecklenburg		
Indicator	**1 – 7 Days**	**8 – 30 Days**	**State Target**
Effective Use of State Psychiatric Hospital	30%	40%	1-7: 44% 8-30: n/a
Timely Follow-Up After State Psychiatric Hospital Care	36%	18%	1-7: 42% 8-30: n/a
Timely Follow-Up After ADATC Care	14%	5%	1-7: 36% 8-30: n/a

Interpretation:

When added to other pieces of information, these data may indicate service gaps and needs beyond what the existing provider capacity can offer. However, because the data are not sorted by service, target population, or other more specific characteristics it is difficult to pinpoint trends or trouble spots.

Relevant NC TOPPS Data

The North Carolina Treatment Outcomes and Program Performance System (NC – TOPPS) system provides information about consumers' demographic characteristics, symptoms, behaviors and activities, service needs, supports and barriers, family and housing issues, and outcome measures collected through a consumer interview during treatment.

One NC-TOPPS question asks "How important to you now is help in services in any of the following areas?" When consumers begin treatment they are asked this question and during follow-up NC-TOPPS they are asked if they received those services.
The service list includes:

- Alcohol or drug cessation
- Child care
- Crisis services
- Education
- Financial
- Food / shelter
- Housing
- Interpretative services

- Jobs
- Legal
- Mental health
- Relationships
- Living setting
- Tobacco cessation
- Transportation

In the NC-TOPPS in which initial interviews were conducted between July 1, 2006 through June 30, 2007, the following services were identified as needed during the initial interview. More than half of the respondents said these are still needed at update times:

Consumer Group	Services Still Needed
Child mental health:	▪ Child care ▪ Crisis services ▪ Food / shelter ▪ Housing ▪ Legal ▪ Living setting ▪ Medical
Adolescent mental health:	▪ Interpreter ▪ Jobs
Adolescent substance abuse:	▪ Child care ▪ Jobs
Adult mental health:	▪ Child care ▪ Education ▪ Food / shelter ▪ Interpreter
Adults substance abuse:	▪ Child care ▪ Crisis services ▪ Education ▪ Financial ▪ Food / shelter ▪ Housing ▪ Interpreter ▪ Jobs ▪ Legal ▪ Living setting ▪ Medical ▪ Transportation

Provider Inventory

Data Related to Cultural & Linguistic Issues

Spanish Language Services:

North Carolina continues to experience dramatic increases in immigration from Hispanic and Latin countries, the vast majority of whom speak little or no English. According to the 2001 U.S. Census, the following chart depicts the percentage of each county's population who identified themselves as Hispanic / Latino. It is not known the exact percentage that also speaks no English.

Specific questions were included in the interviews, forums and surveys to identify the actual and potential need for services designed to serve those with diverse linguistic and/or cultural needs and the provider capacity. Additional information was gathered as available.

The following summarizes these results:

- The need for Spanish language outreach and services was mentioned by many throughout the assessment. They emphasized truly bilingual engagement beyond mere interpretive services.

- Outreach was identified as important as bilingual services; it is assumed that many Hispanic / Latino people in need of services are either not aware of services, have language barriers, or are afraid to access services due to immigration-related concerns.

- The Hispanic / Latino community needs access to the full array of services.

- In addition, children of undocumented residents have a unique about family disruption and dislocation, and are in need of outreach and services.

- Providers in Mecklenburg County report a total of 82 personnel are able to deliver services in Spanish. However, over 30 percent of those responding have no staff who can deliver services in Spanish. Another 27 personnel can deliver services in a language other than Spanish or English. These include: French, German, Swahili, Dutch, Cantonese, Russian, Creole, Tagalog, Hmong, Gujarati and Hindi.

- Providers report only 14 personnel trained to deliver services in sign language. Twenty-seven providers (68% of respondents) have no staff trained to deliver services in sign language.

- NC-TOPPS respondents said their needs for interpreters were not met.

Culturally Sensitive Services for African Americans:

Numerous survey respondents described a need for both awareness and services that recognize and accommodate unique cultural qualities among African Americans in Mecklenburg County, approximately 30% of the county's population (source: Census 2000).

Providers Willing to Assist in Community Disaster Response

Mecklenburg sent electronic survey links to providers to determine disaster response capacity. Forty-four providers of a possible 183 responded. Of those 72 percent responded that they were willing to provide behavioral health care in the event of disaster in Mecklenburg County:

Is your organization willing to provide behavioral healthcare first aid in the event of a disaster in Mecklenburg County?		
Answer Options	**Response Percent**	**Response Count**
Yes	72.1%	31
No	27.9%	12

However, only 25 percent of agency's licensed clinicians and 47 percent of agency's APs and QPs have received disaster training, and 46 percent of agencies do not have additional licensed clinicians willing to receive training. Almost 75 percent of providers have additional AP and QP staff willing to be trained to respond in a disaster. Ninety one percent of agencies (39) are willing to provide staff to work with the LME to participate in community disaster drills.

Provider Agency Trained Staff Ratio and Untrained Staff Willing to Receive Training		
Does your agency have licensed clinicians who have received disaster response training and are available for response?	**Yes**	**No**
	25.0% (11)	75.0% (33)
If no, does your agency have licensed clinicians who are willing to receive disaster response training and be available for response?	**Yes**	**No**
	54.1% (20)	45.9% (17)
Does your agency have QPs or APs or other credentialed staff who have received basic training and can be deployed in a disaster?	**Yes**	**No**
	46.5% (20)	53.5% (23)

If no, does your agency have QPs or APs or other credentialed staff who are willing to receive basic training and be deployed in a disaster?	Yes	No
	73.3% (22)	26.7% (8)

Does your agency have a current disaster plan which includes the following:

Answer Options	Yes	No	Response Count
Plans for sheltering in place and/or for relocating the program	30	14	44
Capacity or a contract in place to transport your consumers away from a disaster site	25	18	43
Call tree and incident leadership structure for disasters	33	10	43
Schedule for running or participating in disaster drills	26	17	43
Designated primary contact for disaster communication	38	5	43
Caseload lists with emergency contacts to reach out to your consumers and/or their families in the event of a disaster	39	5	44
Disaster kits including emergency supplies of medication, toiletries, first aid supplies and water on hand at all times	27	14	41

Would your agency pay salaries to staff to be deployed in the event of a disaster?

Answer Options	Yes	No	Response Count
For up to one week?	29	9	38
For up to two weeks?	9	24	33
For more than two weeks, if needed?	9	27	36

Is your agency willing to open its facilities to consumers from other agencies in the event of a disaster?

Answer Options	Yes	No	Response Count
For up to one week?	28	9	37
For up to two weeks?	19	13	32
For more than two weeks, if needed?	19	17	36

Data Related to Active Military and Veterans

The Mental Health Association is currently working with the local National Guard units to address issues related to Military Personnel and Veterans. Together, they have formed the Community Area Resource Team (CART) committee to address the many needs of local military families and

veterans. They have a group of representatives from the local guard units, the VA, Presbyterian Hospital, DSS, Child Care Resources, Mecklenburg Area Mental Health, Parks and Rec., and Sue Myrick's office.

CART has also established several subcommittees, to include a mental health subcommittee.

It is increasingly recognized that the behavioral healthcare needs of our military service members returning from tours of duty in Iraq and Afghanistan are going unmet according to National Statistics.

The following national statistics describe the current identified needs:

- 20.3% of active and 42.4% of reserve component soldiers are requiring mental health treatment.
- Veterans 18-24 years of age were five times more likely to have PTSD than older veterans.
- Military personnel deployed longer than six months or with multiple deployments are more likely to screen positive for a mental health problem.
- The total of mental health cases among war veterans grew by 58% from 63,767 on June 30, 2006, to 100,580 on June 30, 2007, VA records show. The mental health issues include PTSD, drug and alcohol dependency, and depression. They involve troops who left the military and sought health care from the veterans department.
- The number of Iraq and Afghanistan war veterans seeking treatment for post-traumatic stress disorder from the Department of Veterans Affairs jumped by nearly 20,000 — almost 70% — in the 12 months ending June 30, 2007
- Additional mental health disorders frequently identified include anxiety disorder (24% of reported mental health diagnoses), adjustment disorder (24%), and depression (20%) and substance abuse disorders (20%).
- 12% of active-duty and 15% of reservists had signs of alcoholism six months after returning from combat with less than 1% referred for treatment.
- 3,057 veterans of the Iraq and Afghanistan wars were potentially diagnosed with a drug dependency from fiscal year 2005 through March, 2007, which increased from only 277 from 2002 through 2004.
- Once active military test positive for illegal drugs, many soldiers are often discharged and left without direct access to proper treatment for either their substance abuse issues or common co-morbid PTSD.
- The risk of suicide among male U.S. veterans is double that of the general population. 100% of the 2006 Army Operation Iraqi Freedom suicides were by firearm or gunshot. 86% were male, 93% were 30 years of age or younger, 86% were E4 class or lower, 21% were married and 7% were non-white. Because suicide by gun is the most common method among men, active military are particularly at risk for suicide due to gun availability.
- Military families are also directly affected by their loved one's condition, including education about their family member's disorder and their own treatment or support needs.

Accessing the Community Public System:

Technically the Veterans Administration provides behavioral healthcare treatment to active and veteran military; however active military often seek treatment off-base and outside the VA. There are multiple reasons:

- Gaps in VA services.
- Stigma associated with seeking help and concerns about breaches in confidentiality.
- VA services are not easily accessible in all parts of the country, particularly in rural areas.
- With over 25 million veterans in the United States the VA health care system has an enrolled veteran population of nearly 8 million and expects to treat 5.8 million in 2008 with 263,00 being veterans of Operations Enduring Freedom and Iraqi Freedom.

Consequently, many active and veteran military and their families seek treatment from the community-based public system.

Additional Potential Influences on Provider Capacity

The following three circumstances currently affect the provider community and provider capacity:

Workforce Development

In all data gathering methods, concerns were raised about the quality of front-line staff, particularly among community support staff. The following key problems and issues were identified:

- Quality of provider staff, particularly community support staff, was identified as a significant problem. Staff were described as inadequately trained and supervised. Staff were also described as lacking the right set of skills and competencies to be strong direct care staff, regardless of training or supervision.

- Credential requirements are too stringent for certain substance abuse direct care staff positions and their required supervision, making it extremely difficult to recruit new staff or professionally develop existing staff.

- The NC Division of MH/DD/SA published two reports in 2006 related to workforce issues, including an inventory of licensed mental health professionals and psychiatrists, with the following summary results for Mecklenburg County:

    - General Psychiatrists: 73
    - Child Psychiatrists: 10
    - Forensic Psychiatrists: 0
    - Geriatric Psychiatrists: 0

- Licensed Mental Health Professionals: 1,350

Currently this is the only inventory of behavioral healthcare professionals or paraprofessionals available. Because this includes all who hold state licenses it is unclear how many of these individuals work in or would be willing to work in the public system.

CAP Waiting List Data

Total number of consumers on waiting list:	313
Adults on waiting list:	133
Children on waiting list:	180
Levels of Need Information:	
o Minimal support need:	73
o Moderate support need:	172
o High support need:	64
o Critical need:	4

Accreditation

Providers endorsed to provide enhanced benefit services are required to obtain national accreditation, as early as March 20, 2009. Currently, 84 providers of Mecklenburg County LME are required to secure accreditation. Of those 84, 14 have accreditation and 35 have begun the process. 35 providers have not notified the LME of their status at this time. While there is still time, and while Mecklenburg County LME is providing extensive information and prompting in this regard, some providers may not be able to or may choose not to become accredited. This, too, will affect the provider community, causing gaps or transition issues during fiscal year 2008-09 and beyond.

Both of these situations will continue to be monitored closely as part of managing the provider community.

ACKNOWLEDGEMENTS

Mecklenburg County LME would like to thank the following groups for their assistance in completing this needs assessment:

- The Needs Assessment Steering Committee for its guidance and participation throughout this process.
- The Consumer and Family Advisory Committee and the Planning & Collaboration Committee for its guidance and participation throughout this process.
- Best Practice Committees for their participation throughout this process.
- All others who participated in interviews, forums, and surveys.
- Mecklenburg County LME staff for coordination and compiling information.
- Watauga Consulting for assistance with preparing this document.

APPENDICES

Appendix A: DHHS Requirements for Community Needs Assessment
Appendix B: Mecklenburg County Area MH/DD/SAS Marketing Plan
Appendix C: Mecklenburg County Area MH/DD/SAS Regional Crisis Plan Recommendations
Appendix D: Mecklenburg County Area MH/DD/SAS Practitioner Availability Report
Appendix E: Mecklenburg County Area MH/DD/SAS Cultural and Linguist Competence Plan
Appendix F: Mecklenburg County Area MH/DD/SAS Needs Assessment Overview Presentation

Appendix A

DHHS Contract Requirements

Process Requirements:

- Annual assessment, to occur during the contract's third quarter.
- Quarterly updates.
- Annual and quarterly reports to Board and CFAC.
- Input from consumers, families, and community stakeholders.

Required Components:

The following are specific to the "needs assessment" related section of the contract:

- Catchment area population.
- Number and variety of providers for each service.
- Service array gaps.
- Include information about those providers willing participate in community emergency response efforts (providing services in temporary shelters during evacuations, for example).
- Particularly emphasize crisis service and services that build or enhance community, family, and natural support connections.
- Include an analytical comparison of the proportion of persons served to state norms by population, age, and service type. (These data are generated on a state report.)
- Ensure that children services and CAP-MR/DD services needs are included in the assessment. Specific language reads, "LME shall assess community need and provider capacity for children's services … sufficient number of service providers to ensure that children receive services in settings which are more likely to maintain or develop positive family and community connections."

The following are items from other sections of the contract that seem to relate to needs/gap assessment:

- If the LME hosts a regional deaf services coordinator, the LME must include assessment of community need and provider capacity for consumers who are deaf and hard of hearing.
- Include an analysis of LME expenditures of State funds for prior year shortfalls, to be addressed in development plan. [Assumption: this refers to state allocated funds that were not used during a fiscal year.]
- Medicaid eligible consumers must have provider choice. For those eligible for State-funded services, consumers must have a choice of at least two providers for every service, except for those services with very limited usage.
- LMEs are expected to coordinate with other public, faith-based, and non-profit organizations to increase service options for non-target populations and to increase community supports for all consumers.

- LMEs are expected to explore increasing consumers' access to free or low cost medications, affordable housing, employment, and other supports and services.
- LMEs are expected to participate in the development of a community response plan and work with providers to meet needs of the community in the event of a community-wide disaster or emergency situation.

Additional Monitoring Tool Recommendations:

- Form an assessment steering committee comprised of diverse stakeholders.
- Define Issues and problems to address.
- Collect information from extant and available resources.
- Gather new information in targeted areas.
- Analyze information and define gaps.
- Create plan of action with measurable goals (to include tasks related to provider recruitment, technical assistance, and other provider initiatives.) The Board and CFAC should be active participants in the planning & prioritizing as well as data gathering.
- Share assessment information and plans with Division, Board, CFAC, and broader community.

Community Needs Assessment Monitoring Checklist

Information Requested	Complete
Current year and past year plan	
Minutes of LME staff/Board/CFAC meetings	
NC Topps Data	
Claims Data	
U.S. Census Data	
Input from individuals and family members	
Input from other community stakeholders	
Review CAP/MRDD waiting list to determine patterns of need	
Comparison of proportion of persons served to state norms by specific population	
Provider capacity and willingness to participate in community emergency response efforts	
Cultural and linguistic capacity	
LME updates community capacity assessment on a biannual basis	
LME expenditures of State funds for prior year shortfalls are addressed	
LME should employ a variety of tools to solicit information including surveys and focus groups	
Elements relevant to all of the priority populations as well as movement toward	

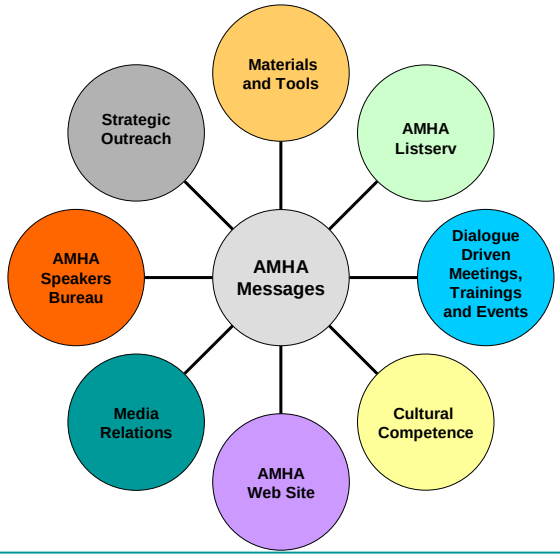
evidence based practices	
Take into account the findings from the last needs assessment	
Address the needs of ethnic and cultural minorities	
The plan of action resulting from the needs assessment should prioritize action items and describe levels of effort in measurable goals	
The LME uses the annual assessment to determine the ability of current providers to meet the needs of clients likely to seek services	
Provider recruitment materials	
Technical assistance requests	
Number of providers recruited in specific priority areas	
Provider monitoring and endorsement reports (summaries)	
Provider surveys	
Provider meeting minutes	
Bulletins	
An analysis of the match between needs identified and the availability and capacity of current providers to meet the needs by population	
Address any shortfalls in the availability of crisis response identified in the assessment	
Identify poorly performing portions of the provider network and specific plans for improvement	
Updates to the LME Board and CFAC on a quarterly basis regarding progress toward meeting the community's need	
Demonstrate that regular and periodic presentations were made regarding the assessment and progress	
Demonstrate that input and advice from Board and CFAC members influenced direction	

AMHA Social Marketing Plan
Mobilizing the Message

March 26, 2008
Presented by Jill Scott
Public Information Specialist
Area Mental Health Authority

Objectives

- **Adult MH Consumers**
  - **GOAL: 40% Prevalence**
- **Child and Adolescent MH Consumers**
  - **GOAL: 40% Prevalence**
- **Adult SA Consumers**
  - **GOAL: 10% Prevalence**
- **Child and Adolescent SA Consumers**
  - **GOAL: 10% Prevalence**
- **Adult DD Consumers**
  - **GOAL: 40% Prevalence**
- **Child and Adolescent DD Consumers**
  - **GOAL: 40% Prevalence**



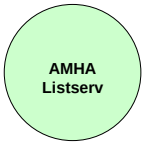
Audiences

- Government Agencies
- Libraries
- Schools
- Faith Community (connect with influencers like Casandra Harding, Parish Nurse, Friendship Missionary Baptist Church)
- Hospitals/Primary Care Physicians
- Non-Profits
- Grocery Chains
- Community Coalitions/Collaborative Groups (i.e. Latin American Coalition)
- Shelters/Crisis Centers
- Urgent Care Clinics
- Minute Clinics (CVS, etc.)

Materials and Tools

- Brochures
- Pocket Cards
- Promo Items
- Fact Sheets
- Handbooks
- PowerPoint Presentations
- Newsletters
- Video production
- Media Relations
- Listserv

AMHA Listserv



- Weekly community e-bulletins that encourages community engagement:
- The AMHA Community Table—the HUB for information/resources on MH/SA/DD in our community
- Can sign up online to receive them
- Listserv e-Bulletins will highlight:
  - News
  - Events
  - Policy
  - Community engagement activities, community partnerships
    - Start Date: April 16, 2008
    - Frequency: Weekly
    - Resources Needed: Fabulous template, willingness to offer info
    - Persons Responsible: Jill Scott, Crystal Stillwell, Emerson Morrison

Meetings, Trainings and Events, OH MY!

- Educating the community about resources and process
- Area Mental Health Authority Community Table
- Asking for feedback and involvement in decision-making
- Memberships in the community/presence at other entry-points
- Position ourselves as the central resource for mental health in the community
  - Start Date: May 2008
  - Frequency: Monthly
  - Resources Needed: Participation from AMHA representatives, assistance in coordinating and event planning
  - Persons Responsible: Jill Scott, AMHA Management Team, MeckCARES Staff, Provider Relations

Strategic Outreach Priorities

- Faith Community
  - Partner with faith community to co-lead workshops on MH/SA concerns and resources
- Primary Care Physicians/Hospitals
  - Start Date: April 2008
  - Frequency: Monthly
  - Resources Needed: Help identifying 100 largest, most culturally diverse and most influential churches. Help from Carolinas Healthcare identifying best distribution methods
  - Persons Responsible: Jill Scott, Carlos Martinez, MeckCARES Staff, AMHA Speakers/Representatives

Cultural Competence

- Involve interpreters in social marketing efforts
- Attend community fairs and events and partner with local organizations that will act as cultural brokers
- Promote cultural competence and community engagement values in all AMHA messaging
- Open up our own events and activities to the general public and targeted communities
- Establish a budget specifically for cultural competence events/social marketing/translation services

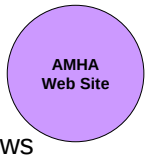
AMHA Speakers Bureau

- Organized through AMHA Web Site/Listserv
- Promote Speakers Bureau and topics of interest in the community
  - Start Date: May 2008
  - Frequency: As necessary
  - Resources Needed: Participation from Speakers in training session. Powerpoint and additional tools.
  - Persons Responsible: Jill Scott, Barbara Cross, AMHA Speakers/Representatives

Potential Speakers

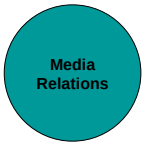
- Grayce Crockett
- Carlos Hernandez
- Dennis Knasel
- Debbie Dukes/Pat Ennes
- Jill Scott
- Kimm Campbell
- Carlos Martinez
- Kim Phillips
- Harvey Blackmon
- Charmaine Carter
- Otis Stroud
- Winona Chestnut
- Connie Mele
- Raquel Cox-Tennal
- Nancy Cody
- Dr. Peterson-Vita
- Roxie Johnson
- Bill Battaile

AMHA Web Site

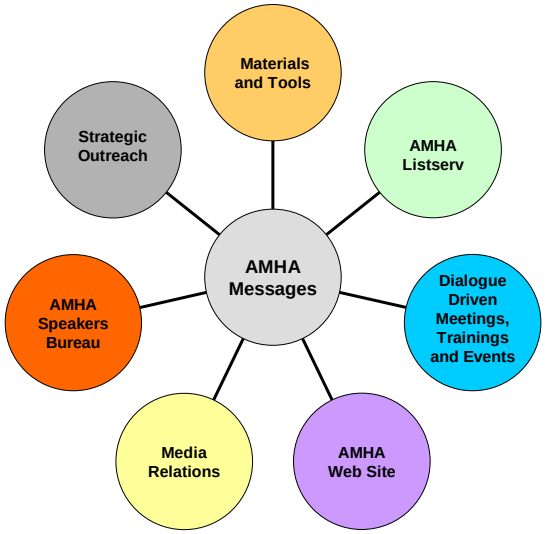


- Maintain our own information, announcements and news
- Become a regional warehouse of resource materials for the community on a variety of issues:
  - Housing, signs/symptoms,
  - Links to other sites
  - FAQ sheets/handbooks/materials from non-profits, feds, etc.
  - Grassroots campaign materials, supply citizens with teaching tools to empower them to reach greater audiences, send others materials, spread the word, and volunteer (political campaigns)
    - Start Date: Resources/Take Action section added April 2008
    - Frequency: ongoing, weekly updates
    - Resources Needed: Assistance from Crystal Stillwell, help identifying most important resources for divisions, issues, etc.
    - Persons Responsible: Jill Scott, Crystal Stillwell

Media Relations



- Highlighting our own as well as collaborative and consumer events
- Awareness dates, initiatives and
- Raise awareness about scope of issues in our community using local data
- Healthwise segments
- Salud y Vida
  - Start Date: March 2008
  - Frequency: ongoing, as necessary
  - Resources Needed: information from various divisions, need cultural brokers and assistance with Spanish language media outlets
  - Persons Responsible: Jill Scott, PS&I Team



Appendix C

REGIONAL CRISIS PLAN RECOMMENDATIONS

The LME initiated regional crisis planning activities by conducting a Focus Group with key community partners and stakeholders in September, 2006. The LME then formed a Regional Crisis Planning Committee which has met 3 – 4 times/month since September. The Focus Group discussion, along with the previously completed inventory of crisis services, Communication Bulletins (CB) # 35 and # 61 and a study of the current status of crisis services (completed in 2005 in response to CB # 35) formed the basis of initial discussions. The Committee was made up of representatives from the two local major hospital corporations (Carolinas Medical Centers and Presbyterian/Novant), CFAC, LME Utilization Management and STR, service providers for each age/disability group (MH, DD, SA, child/adolescent and adult) as well as representative of services including community support, residential, inpatient, outpatient, ER, CSU, mobile crisis, MR/MI, SA services, CAP, diagnostic assessments, etc.

Collaboration with the MH/SA Jail Diversion Work Group (JDWG) revealed that the JDWG is developing plans for a facility based, pre-booking assessment program. The JDWG has experts representing many areas, but in particular, the Jail, Crisis Services, Treatment, Housing and the Mental Health Court. The committee reviewed models from across the Country that had effective Jail Diversion programs. Development of the Jail Diversion program comes at a time when and complements the Sheriff's plans in response to jail overcrowding. The AMH Director made a presentation to the BOCC Health Committee in the fall, immediately following the Sheriffs' presentation on the Overcrowding. Another presentation was made to the BOCC on Feb 20 with a recommendation for a specific Jail Diversion Model.

Barriers, state of readiness, milestones:
1. Dollars to support the development and maintenance of this model – is the biggest barrier.
2. State of Readiness is really dependent on capability to convert a current facility or to build a new one.
3. The biggest milestone is that we were able to bring all of these stakeholders together to effectively work on the development of this model.

The committee continued to operate as a working committee and extended the project to include other community partners, working in sub-committees and in collaboration with existing community collaborative groups including CFAC, the Planning and Collaboration Committee, the Mental Health /Substance Abuse Jail Diversion Stakeholders Work Group (JDWG), the Homeless Services Network and Charlotte Mecklenburg Schools, System of Care Collaborative, community advocacy agencies and others. Tasks have included the following:

- Developed Guiding Principles in collaboration with CFAC

- Literature review re successful crisis continuum models
- Data gathering across all MH/DD/SA services with a focus on service utilization and gaps

The Committee determined that while Mecklenburg County has components of a fairly well-developed crisis continuum in place, services are fragmented. Both access and coordination are problematic. There is no centralized route to access crisis services or to triage, screen and coordinate crisis and service delivery to assure that the most appropriate level of care is provided in the least restrictive and most effective and efficient setting. In response to these problems, the Committee has recommended, among other things, that a regional crisis facility be developed to operate as a facility based, centralized crisis center and that this facility be developed and implemented in conjunction with the planned jail diversion program. A survey of 1st responders indicates that among clinical home providers randomly called, only 30% of clinical home providers had a 24/7 1st responder system in place. Transport is a problem with law enforcement as the only reliable transport in place for persons in crisis.

The Committee recommends development of a centralized, facility-based crisis service. The facility will operate as a "crisis central" point of entry 24/7 for telephone, walk-in screening, triage, assessment and referral for any and all MH/DD/SAS crises for adults and children. The facility will operate in conjunction with the pre-booking jail diversion program for persons under arrest who may have an undiagnosed MH or SA problem. Collaborations are underway with the CMPD to implement a CIT program.

Components of a Regional Crisis Center will include the following:

- No wrong-door – persons may access services directly or from any community referral source including the Mobile Crisis Team which may determine that a person can be appropriately served at the Crisis Center
- No refusal policy, all persons welcome 24/7
- Transportation - a safe/secure transportation system staffed by paraprofessionals trained to handle persons with MH/DD/SA crises
- Serving Mecklenburg County residents ages 13 and up
- Immediate triage by Registered Nurse
- Coordination and referral/access to a more appropriate level of service including Intensive In-Home for children or intensive Therapeutic Crisis Respite for children and for persons with developmental disabilities as well as MH/SA needs
- If needed, Urine Drug Screen and blood work for detection of medical emergencies and chemical abuse
- Complete psychosocial assessment and evaluation
- Length of stay is 23 hour observation to seven days
- Staffing includes a mix of healthcare professionals such as Registered Nurses, Physician Extender, Psychiatric/Substance Abuse professionals, Discharge Planner and Security Officers

- Sections of the Crisis Center are locked and secured to prevent elopements of high risk consumers
- After an initial assessment, each person is placed in one of 4 sections: one designated for persons with developmental disabilities, one for adolescents, one for mental health and/or substance abuse clients and one for jail diversion.
- Each section will include furnished sitting area, common kitchenette and appropriate bed space
- An additional section will be available as private or semi-private rooms for consumers remaining in the facility more than 24 hours
- Interventions may include community support, crisis counseling, medication management, detox, and other services as needed
- After crisis is resolved, the person is transitioned to appropriate aftercare, community treatment and/or residential stabilization.

SUMMARY OF DATA and/or MOA's THAT SUPPORT LOCAL PLAN			
List of Data Sources or MOA's	**Time Span**	**Data Attached in Regional PDF? Y/N**	**Data Limitations or Other Notes**
Guiding Principles Document	FY06	**Y**	Crisis Plan Guiding Principles
Service Gaps and Access Document	FY06	**Y**	Mecklenburg LME Crisis Services Gaps
Community Partners Letters of Support	Feb. 07	**Y**	15 Letters in one PDF file
Consumer Flow-Thru Jail Diversion	Draft	**Y**	Draft Flow Chart
County Medicaid Distribution	Aug-06	**Y**	MeckMedicaidMap
1st Responder CFAC Survey	FY06	**Y**	Limited one-time survey
Mecklenburg Co. Substance Use/Abuse Data	2005-2006	**Y**	Summary Data Report
Mobile Crisis Service Utilization	FY06	**Y**	Mobile Crisis Data - June - Dec 2006
Emergency Room Visits	FY06	**Y**	CMC ER Data Report
CSU Average Census	FY06	**Y**	CMC ER Data Report

Inpatient admissions to State Hospital	FY06	**Y**	Combined Admissions Data Report
Inpatient admissions to local psychiatric hospitals	FY06	**Y**	Combined Admissions Data Report
Admissions to Detox services	FY05	**Y**	Combined Admissions Data Report
Triage Level 4's and 5's	FY06	**Y**	Combined Admissions Data Report
Detention Data	FY06	**Y**	Combined Admissions Data Report
Police Transport Data	FY06	**Y**	ER and Detox Police Transports
Housing and Homelessness Data	2006	**Y**	Housing and Homelessness Data

Appendix D

Mecklenburg Area Mental Health, Developmental Disabilities and Substance Abuse Authority

Practitioner Availability Summary

JANUARY 1, 2006 to DECEMBER 31, 2007

Introduction

Assuring there are adequate numbers and geographic distribution of contracted practitioners is an essential component of managed care quality. Behavioral health practitioners provide key services to members. In 2007 the Local Management Entity (LME) of Mecklenburg Area Mental Health, Developmental Disabilities and Substance Abuse Authority continued to monitor standards established in 2003 and amended in 2005 and 2006 for adequate numbers and geographic location of providers of specialty care services. Specialty care providers selected, on the basis of acute care and crisis stabilization needs, include: inpatient treatment, residential crisis stabilization, social setting detoxification, 24-hour psychiatric emergency room services, forensic evaluations, and mental health Community Support*. In addition, Mobile Crisis Service was added in 2006. This service provides on-site psychiatric crisis intervention to consumers in the community. The majority of services provided by the LME are Community Support services. This service is provided in the community, at the consumer's residence or other sites as needed. This is not a facility-based service provided in a practitioner's office. Non-urgent and non-emergent consumers in need of a face-to-face assessment to determine diagnosis and appropriate treatment are referred to assessment providers. Licensed clinicians (psychologists, clinical social workers, professional counselors) provide the assessment in an outpatient office or clinic setting. The time interval for measurement of these services is calendar year 2007.

Annually, the LME measures compliance with practitioner availability standards, identifies opportunities for improvement and implements actions to improve performance. In addition, the LME monitors data on member cultural needs and preferences, and makes changes in the network as needed.

This report includes the results of monitoring practitioner availability from a variety of sources, including: consumer satisfaction surveys; complaint data; census data; and agency capacity and utilization information. It then compares the results to established standards and, when necessary, recommends focused interventions to improve availability.

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*The term Community Support (previously referred to as *Mental Health case management)* as used in this report is a service provided by Mecklenburg LME.

Community Support is defined as an intensive and focused clinical intervention provided primarily in face-to-face contact with consumers. Community Support is provided in the community at a site where the consumer is located, not in a clinic or office. The service includes assessment, diagnosis, treatment planning, psycho-social treatment and the arrangement, linking and monitoring of service delivery.

Assessment of Geographic Distribution

The Mecklenburg LME geographic catchment area includes all of Mecklenburg County. Residence within the county is a required criterion for member inclusion. The county radius is no more than 30 miles. As indicated previously, the highest volume service provided is Community Support. This service is not facility- or office- based but provided throughout the community; that is, the Community Support provider goes to the consumer, rather than the consumer to a service location. Providers of office- and facility-based services are distributed throughout the 30 mile county radius; therefore, all members are within thirty (30) miles of practitioners. The highest volume office-based service is medication management. The LME's standard for Medication Clinic is two (2) within thirty (30) miles. LME's standard for inpatient treatment, residential crisis stabilization, social setting detoxification, and 24-hour psychiatric emergency rooms is one (1) facility of each type within thirty (30) miles. The standard for Mobile Crisis Management is one provider agency within 30 miles. All LME facilities for these services are centrally located within thirty (30) miles of all consumers.

Table 1 summarizes the availability standards, monitoring methodology and assessment of geographic distribution. Case management is not included due to the fact it is not an office- or facility-based service.

Table 1

Location Type	Standard	Methodology	Frequency	Standard Met
Medication Clinic	*2 providers within 30 miles*	*GeoAccess*	*Annually*	*Yes*
Child/Adolescent Inpatient	*1 provider within 30 miles*	*GeoAccess*	*Annually*	*Yes*
Adult Inpatient	*1 provider within 30 miles*	*GeoAccess*	*Annually*	*Yes*
Adult Residential Crisis Stabilization	*1 provider within 30 miles*	*GeoAccess*	*Annually*	*Yes*
24 Hour Psychiatric ER	*1 provider within 30 miles*	*GeoAccess*	***Annually***	***Yes***
Mobile Crisis Services	*1 provider within 30 miles*	*GeoAccess*	***Annually***	***Yes***
Adult Social Setting Detoxification	*1 provider within 30 miles*	*GeoAccess*	*Annually*	*Yes*

Four types of information are used to assess member cultural needs and preferences for the practitioner network. Data from the 2000 census and the 2006 American Community Survey (ACS) estimates about the cultural characteristics in the service area are used to anticipate potential member needs (Table 2). The health plan monitors member requests and complaints related to practitioners who meet specific cultural needs and preferences (Table 3). The health plan also monitors enrollees' satisfaction related to cultural sensitivity in the annual Customer Satisfaction Survey. Satisfaction goals were met in 2003 and continued to be monitored in 2004, 2005, 2006 and 2007. The level of satisfaction for 2007 dropped by 4 percentage points from 2006 and by 1 percentage point from the baseline established in 2003. Nevertheless, the level of satisfaction remains above the goal.

Census Data on Non-English Speaking Population in Service Area

Table 2 provides a breakdown of the language spoken at home for non-English speakers in Mecklenburg County. The 2006 Census data are from the 2006 American Community Survey (ACS) estimates. Languages included are non-English languages representing an approximation of at least 1% of members.

Table 2 – Census and LME Data

Language Spoken	2006 ACS Survey	% of Total Population	2007 LME Consumers	% of Consumers
Spanish	81,090	9%	24	1.1%

Table 3 - Summary of Member Requests for Specific Practitioner Characteristics

Data Type	Number of Member Requests	Explanation of Member Requests
Member complaints	0	No verbal or written complaints made.
Requests to change practitioners	0 (measured only through June)	No verbal or written requests or complaints made.
Member satisfaction survey – Question #13	See Table 4	

Data Type	Number of Member Requests	Explanation of Member Requests
Requests to add specific practitioners to network related to cultural or ethnic preferences	0	There were 240 callers who chose the Spanish language option at the STR function.

Table 4 summarizes member satisfaction in response to a question on a member satisfaction survey.

Responses indicate the percent of respondents who reported **"Agree or Strongly Agree"** to the Statement: **"Staff are sensitive to and respect my cultural and ethnic background"**.

Table 4 - Summary of Member Satisfaction Survey

Year	Goal	2003 (baseline)	2005	2006	2007	Goal Met
Total	85%	88%	88%	90%	86%	Yes

Member Satisfaction

Data in table 4 indicates that the goal for customer satisfaction continues to be met. There is minor variation each year since 2003. Likewise Table 4 continues to show a continuing trend of no complaints. Increasing numbers of customers have requested Hispanic language providers.

Language Interpretation Services

The LME provides interpretive services when needed to overcome language barriers. Network providers are required by contract to identify services where an interpreter is needed and to make interpreters available.

Cultural and Linguistic Characteristics of Practitioner and Provider Network

Given the increase in the Latino population, the LME took the initiative in 2006 to hire a bilingual call center staff and a bilingual outreach coordinator in anticipation of increased need and requests for services for Latino members. The percent of Latino members to total members falls short of the population ratio at this time. It is projected that there are numbers of underserved members in this group and that this number will grow as availability of practitioners who are bi-lingual and bi-cultural increases. Due to this projection and the number requests for Hispanic language practitioners the LME continues to vigorously

urge provider agencies to add qualified clinical bilingual (Spanish/English) staff and will continue to do so. A survey conducted in 2007 showed a total of 10 out of 23 Community Support provider agencies with Bi-Lingual staff available for Community Support or Targeted Case Management as reported below in Table 5.

Table 5 - Summary Hispanic Practitioner Availability Survey

Year	Goal	2007	Spanish Language Staff Available	2007	Goal Met
Total	9%	23 Agencies	10 Agencies	43%	Yes

The Monitoring and Evaluation Plan

Table 6 summarizes the availability standards and monitoring methodology for acute care and high volume specialty services.

Table 6 Summary of Monitoring of Practitioner Availability

Service Type	Standard	Methodology	Frequency
Adult Community Support	*8 Community Support Staff per 1000 members*	*Ratio or number of case managers divided by number of adult consumers.*	*Annually*
Child/Adolescent Community Support	*15 Community Support staff per 1000 members*	*Ratio of number of child/adolescent case managers divided by number of child/adolescent members*	*Annually*
Developmental Disabilities Targeted Case Management	*20 Case Managers per 1000 members*	*Ratio of number of developmental disabilities case managers divided by number of developmentally disabled members*	*Annually*
Medication Clinic	*2 clinics available*	*Availability*	*Annually*
Child/Adolescent Inpatient	*5 beds per 1000 child/adolescent members*	*Ratio of number of patient beds divided by number of child/adolescent members*	*Annually*
Adult Inpatient	*4 beds per 1000 adult members*	*Ratio of number of patient beds divided by number of adult members*	*Annually*
Adult Residential Crisis Stabilization	*.5 beds per 1000 members*	*Ratio of number of patient beds divided by number of adult members*	*Annually*

Service Type	Standard	Methodology	Frequency
24 Hour Psychiatric ER	*24 Hour Psychiatric ER Available*	*Availability*	***Annually***
Mobile Crisis Service	24 Hour Mobile Crisis Services Available	*Availability*	*Annually*
Adult Social Setting Detoxification	*3 beds per 1000 members*	*Ratio of number of patient beds divided by number of adult members*	*Annually*
Court Related Evaluations	*2 Credentialed Forensic Evaluators per 1000 members*	*Ratio of number of Forensic Evaluators divided by number of members*	*Annually*

Results and Analysis

Table 7 summarizes the results of the availability monitoring and compares performance to the goal.

Table 7 Availability Summary

Service Type	Availability Standards	Actual Availability	***Standard Met?***
Adult Community Support	8 Community Support staff per 1000 members or .8 per 100 members	2 per 100	Yes
Child/Adolescent Community Support	15 Community Support staff per 1000 members or 1.5 per 100 members	10 per 100 members	Yes
Developmental Disabilities Targeted Case Management	20 Case Managers per 1000 members or 2 per 100 members	7.9 per 100	Yes
Medication Clinic	2 clinics available	3 clinics in place	Yes
Child/Adolescent Inpatient	5 beds per 1000 child/adolescent members	17/100	Yes
Adult Inpatient	4 beds per 1000 adult members	8.5/1000	Yes
Adult Residential Crisis Stabilization	.5 bed per 1000 members	.9/1000	Yes
24 Hour Psychiatric ER	24 Hour Psychiatric ER available	24/7 Psychiatric ER in place	Yes
Mobile Crisis Services	*24 Hour Mobile Crisis Provider available*	24/7 Mobile Crisis Service in place	Yes

Service Type	Availability Standards	Actual Availability	*Standard Met?*
Adult Social Setting Detoxification	*3 beds per 1000 members*	5.3/1000	Yes

Analysis of Availability

Data collected indicate that for all services measured practitioner availability standards were met or exceeded. This is a continuation of positive results from 2006.

The number of members has increased for all populations. The number of Community Support providers has increased and relative to the number of members, the ratio continues to fall well within the standard. The number of inpatient beds for adults and child populations remained static and availability continues to be above the standard. The same is true for Adult Residential Crisis Stabilization and Adult Social Setting Detoxification

Actions Taken

- Completed survey of Community Support providers to determine number agencies with bilingual staff.
- Provided training and information to providers re the growing Hispanic bilingual population and urged them to add bilingual staff.
- Continued Spanish classes for LME staff
- Continued to provide Cultural Competency Training for LME supervisors and managers
- Completed comprehensive Regional Crisis Services Plan which identified gaps in crisis services and recommendations for adding or amending crisis services.

Summary and Recommendations

An assessment of the geographic distribution of facility-based provider sites indicated that all sites are located within a 30-mile radius of Mecklenburg County residents and thus meet established standards for geographic distribution. The highest volume service is Community Support, which is a community-based service. While the number of members and the number of practitioners have both decreased, the number of members fell off proportionately more than the number of providers resulting in an increase in availability.

An analysis of member linguistic preferences indicated no requests for specific practitioner characteristics, and there have been no complaints related to cultural, ethnic, or linguistic preferences. Member satisfaction with respecting cultural/ethnic background, as measured by the 2006 NC Customer Satisfaction

Survey demonstrated continued high levels of satisfaction from the baseline established in 2003. At the same time, recognizing a growing Latino/Hispanic population in the County and consumers, the LME has taken measures to increase the availability of bilingual providers.

A review of the availability standards indicated that all service types monitored were at or above standard. In all cases, this is a continuation of trends from previous years. Mobile Crisis services was added to the continuum of 24/7 crisis services. This improves availability and access by making crisis intervention services available at the site of crisis in the community.

Recommendations:

- *Mecklenburg LME should continue to monitor member requests for specific practitioner cultural, ethnic, or linguistic characteristics.*
- *The LME should continue to promote an increase in numbers of bilingual practitioners.*

Committee Review Summary

The following committees reviewed the Practitioner Availability Summary Report. Their recommendations are listed in Table 8.

Table 8 Committee Review and Recommendations

Committee Name	Review Date	Recommendations
Quality Management Committee	**3/24/08**	**Report accepted.**

Appendix E

Mecklenburg Cultural and Linguist Competence Plan

GOAL #1

Year One - ORGANIZATIONAL VALUES: To enhance Mecklenburg AMHA's perspective and attitudes regarding the worth and importance of cultural competence, and its commitment to providing culturally competent care.

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INIDCATORS	TIMELINE	DATA SOURCES
To enhance commitment to becoming a more culturally competent organization through Leadership, Investment, and Documentation Efforts.	1.Presence of overall investment in cultural competency.	• Approval to train six AMHA staff for Cultural Competence training. • Cultural Competence training made mandatory. • Separate manager/supervisor training • Cultural Competence consultants' contract budgeted. • Cultural Competence Team established. • Bi-weekly communication about Cultural Competence news and events (Grapevine). • Cultural Competence news and events posted online. • Lunch & Learn series established. • Lunch & Language series established • Development of CC Plan.	• % of staff who have been trained • Contract Completed • % of articles/notices appearing in Grapevine • Frequency of postings online • Implementation of Lunch & Learn and Lunch & Language • Completion of CC Plan	• Ongoing • Done 5/07 • Ongoing • Ongoing • Anticipated Completion Date of 1/08	• Training Register • Actual Contract • Grapevine • Online Postings • Actual CC Plan
	2. Presence of Cultural Competency Principles and Practices reflected in agency's mission.	• Request CCAC to review new mission and vision statements as they are developed.	• Mission and Vision Statement reflects Cultural Competence	• 6/08	• Actual Mission and Vision Statement
	3.Presence of Cultural Competency Plan in organization's Strategic Business plan.	• Identify where/if Cultural Competency statements exist in current strategic plan. • Ensure that Cultural Competency Plan is emphasized in strategic plan.	• Existence or non-existence of CC statements.	• Review 3/08 • Add new section 5/08 for FY09	• Actual Strategic Plan • Minutes(L. Team)

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INIDCATORS	TIMELINE	DATA SOURCES
.	4.Presence of an individual at the executive level responsible for and have authority to monitor implementation of the Cultural Competence Plan.	• Identify an individual to fulfill the role of Cultural Competence Advocate. • Introduction of the Cultural Competence Advocate and promotion of their role.	• CC Advocate is named. • CC Advocate is introduced.	• 6/08	• Selection of CC Advocate • Grapevine, Intranet, Hot Sheet.
	5.Evidence of staff's awareness, input, and acceptance of cultural competency plan.	• Identify community events and attend most applicable to the mission of the Cultural Competence Team – share with staff via internal communications. • Present completed Cultural Competence Plan to AMHA Managers and Supervisors. • Present completed Cultural Competence Plan to community of providers outlining expectations for Cultural Competence Training. • Survey providers: Are they aware of the Plan? Are they aware of the training expectations? • Culture Competence Advisory Committee distributes modified version of the Plan (in brochure or fact sheet format) to their own constituencies. • Update and maintain Cultural Competence section of the AMHA web sites and find ways to have provider web sites link to the plan. • Present completed CC Plan to AMHA Managers and Supervisors. • Staff will have attended trainings. • CC Team collects feedback/data from trainings. • Implementation of CC into staff work	• Investigation & selection of Community Events • Plan is presented in Supervisors and Managers meetings • Provider Relations develops a plan for distribution • CCAC distributes modified plan • Staff are aware of plan's existence • % of staff who have been trained	• 5/08 • Ongoing • 3/08 • 6/08 • 6/08 and ongoing • 12/08 • 3/08 • 6/08 • Begin 9/08 • Ongoing	• Community Calendar • Agenda & Minutes from Mgrs, Supervisors • Meeting • Modified Version Of CC Plan • Training Register • Grapevine, Intranet

		plans. • Bi-weekly communication with staff and providers (Grapevine and Hot Sheet) • Information about CC Plan.			

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INIDCATORS	TIMELINE	DATA SOURCES
2. To improve information and data collection processes, procedures, and practices relevant to culturally competent planning, programs, and services.	1. Conducts regular organizational self-assessments regarding Cultural Competency.	• Review, evaluate, update, and administer existing assessment annually. • Create a yearly summary of data to present to AMHA Management Team.	• Process implemented for conducting self assessment • Presentation of Summary to Mgmt.	• 9/08 • 6/08 and than annually.	• Findings from Self-Assessment • Listing of summary in minutes
	2. Implement outlined Cultural Competence Activities.	• Link staff and community at large with cultural happenings and initiatives in the community: AMHA becomes a touchpoint for cultural information in Charlotte-Mecklenburg.	• Identification of Events related to CC.	• Initial - 6/08 • Ongoing	• Community Calendar • Grapevine, Hot Sheet, Intranet

Year Two - ORGANIZATIONAL VALUES: To enhance Mecklenburg AMHA's perspective and attitudes regarding the worth and importance of cultural competence, and its commitment to providing culturally competent care.

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INIDCATORS	TIMELINE	DATA SOURCES
To improve information and data collection processes, procedures, and practices relevant to culturally competent planning, programs, and services.	3.Obtains consumer-level Cultural Competency information.				
	4.Conducts regular community needs assessments.	• CC Team and stakeholders establish some basic questions to include in community surveys to gather baseline data (Urban Institute's Annual Survey, the Provider/ Consumer Survey).	• Identify surveys where the questions could be incorporated	• 12/08 and annually	• Actual Surveys
	5.Requires/facilities regular individual provider assessments regarding Cultural Competency.	• Work with Provider Relations to establish a mechanism for assessing evidence of providers' Cultural Competence implementation.	• Provider Relations includes CC in its Performance Review Tool	• 5/08 and ongoing annually	• Performance Review Tool
	6.Documentation of monitoring, evaluation of implementation and results of Cultural Competency plans as a part of QI.	• Work with Provider Relations to establish a mechanism for assessing evidence of Providers' Cultural Competence Implementation.	• Provider Relations measures and includes CC in its performance reviews	• 5/08 and ongoing annually	• Actual Performance Review Findings
	7. Evaluates Cultural Competency related activities.	• Evaluate number of staff and providers trained. • Evaluate feedback from employee, community, and provider surveys.	• % of Staff & Providers trained • Employee	• 9/08 and annually	• Training Registers • Actual Evaluations

		• Measure community interest (web site hits, mailing lists, media audits) • Lunch & Learn attendance and feedback. • Lunch/Language attendance feedback.	Feedback		• Employee Feedback
Objective	**INDICATORS**	**ACTIVITIES**	**PERFORMANCE INIDCATORS**	**TIMELINE**	**DATA SOURCES**
To improve information and data collection processes, procedures, and practices relevant to culturally competent planning, programs, and services.	8. Documentation of Community/Consumers Cultural Competency.	• Conducts annual community needs assessment	• Community Needs Assessment is initiated	• 12/08	• Actual Assessment
	9. Presence of an individual at the executive level responsible for and have authority to monitor implementation of the CC Plan.	• Selected CC advocates demonstrates they are active in role and fulfilling duties.	• CC Advocate develops a yearly report with a summary	• 06/09	• Actual Report
To enhance commitment to becoming a more culturally competent organization through Leadership, Investment, and Documentation Efforts.	1. Evidence of consumer/community awareness and acceptance of Cultural Competency Plan.	• Identify community events and attend most applicable to the mission of CC team (outreach). • Present completed CC Plan to community of Providers outlining expectations for CC training. • Survey providers (Are they aware of The Plan; Are they aware of the training expectations). • CCAC distributes modified version of the Plan (in brochure or fact sheet format) to their own constituencies.	• Identify applicable community events. • Distribution of Plan to Providers • Distribution of Modified Plan		• Calendar of Events • Actual Modified Plan
	2. Presence of accountability by each individual manager for the success of the Cultural Competence Plan based on his/her level within the organization.	• Managers/Supervisors measured on the implementation of CC performance elements into all staff work plans.	• % of staff work plans with CC performance elements	• 12/08 & annually	• Actual Staff Work Plans

	3. Presence of Cultural Competency Plan in organization's Strategic Business plan.	• Work Plans for all staff include CC performance measures. • Ensure staff is aware that CC performance measures are a part of work plans (can incorporate fun quizzes, giveaways, promotional events to test knowledge).	• % of staff work plans • Development of CC Learning Activity Data Base.	• Thru FY09 & staggered • Beginning 6/09 and ongoing	• Actual Staff Work Plans • Staff participation rate With CC activities.

GOAL #2

Year One: - GOVERNANCE : To improve the goal-setting, policy-making, and other oversight vehicles to help ensure the delivery of culturally competent services

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	DATA SOURCES
1) To enhance community engagement and commitment through increased involvement and accountability (collapsed 1 and 5 objectives)	1. Communication tools consistently address cultural competence	• Annual consumer newsletter • Bi-weekly Grapevine • Weekly Hot Sheet • Quarterly InfoShare	• Positive feedback from InfoShare related to CC activities/education •		• Feedback forms from InfoShare
	2. Plan for engagement of diverse community groups	• Development of Social Marketing plan • Creation of Cult. Comp Advisory Committee • Development of partnerships to diverse community groups/agencies providing supportive services to diverse populations	• CCAC has regular attendance by diverse community groups • Increase in numbers of partnerships w/ diverse community agencies/groups • Identify linguistically competent providers and distribute list to MeckLINK and		• CCAC meeting minutes, attendance roster. • # of active community partners • % of diverse ethnic/racial groups on advisory committees, boards, and planning groups • On-site assessment of linguistically competent provider

			advocacy groups • Develop web-based Spanish-language provider director		
Objective	**INDICATORS**	**ACTIVITIES**	**PERFORMANCE INDICATORS**	**TIMELINE**	**DATA SOURCES**
2) To create opportunities for consumer, staff, and community input	1. Process for staff input into the development of the Cultural Competence plan	• Initial agency assessment of Cultural competence • Develop and distribute surveys related to cultural competence activities • Staff participation in CC training which includes CC Plan development	• Positive ratings of cultural competence activities • Positive ratings of CC training	•	• Result of agency assessment • Data from survey • Training evaluation data
	2. Process of consumer/community input in the development of cultural competence plans, activities, and issues	• Creation of Cult. Comp Advisory Committee • CCAC provides input to CC committee • Consumer focus groups • Provide CC plan and information to CFAC	• CCAC meeting minutes reflect development of input for CC committee • Input from focus groups incorporated into CC activities • Input/feedback from CFAC	•	• CCAC meeting minutes, attendance roster • CC committee meeting minutes • CFAC meeting minutes

3) To develop and finalize a Cultural Competence plan (inserted this as it seemed that first we need to have a final plan	1. Presence of a CC plan	• Development of a draft cultural competence plan	• Approval and support of CC Plan by LME Senior Management • Approval of CC plan by Board	•	
4) To align policies and procedures with culturally competent principles and practices	1) Policies and procedures reflect awareness and importance of cultural competence in any relevant areas	• Review and assessment of current policies and procedures • Review of provider agencies P&P and treatment practices to ensure alignment with CC principles and practices •	• Assessments approve P&P or provide input for revision • P&P are approved by governing body • Provider agencies P&P and practices are linguistically competent	•	• Assessment results • Monitoring visits and other onsite assessment of provider agencies
Objective	**INDICATORS**	**ACTIVITIES**	**PERFORMANCE INDICATORS**	**TIMELINE**	**DATA SOURCES**
5) To enhance Senior Management's understanding of the importance of developing a culturally competent agency	1) Senior management team members are trained in cultural competence principles and practices 2) Education sessions are available for Senior management team and CCAC members	• Training of Senior management team in CC • Management team regularly reviews CC plan, progress, and ongoing issues related to cultural competence	• % of Senior management completing CC training • % of CCAC members complete CC training • Meeting minutes from Mgmt reflect ongoing discussion of CC issues	•	• Training roster • Mgmt team minutes

Year Two - GOVERNANCE : To improve the goal-setting, policy-making, and other oversight vehicles to help ensure the delivery of culturally competent services

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	DATA SOURCES
1)To enhance community engagement and commitment through increased involvement and accountability (collapsed 1 and 5 objectives)	1. Communication tools consistently address cultural competence	• Annual consumer newsletter • Bi-weekly Grapevine • Weekly Hot Sheet • InfoShare	• Positive feedback from InfoShare related to CC activities/education		• Feedback forms from InfoShare
	2. Plan for engagement of diverse community groups	• Demonstrate evidence of input from diverse advisory groups into refinement of CC plan • Continue existing partnerships to diverse community groups/agencies providing supportive services to diverse populations and develop new partnerships	• CCAC has regular attendance by diverse community groups • Increase in numbers of partnerships w/ diverse community agencies/groups • Identify linguistically and culturally competent providers and distribute list to MeckLINK and advocacy groups	•	• CCAC meeting minutes, attendance roster. • # of active community partners • % of diverse ethnic/racial groups on advisory committees, boards, and planning groups • On-site assessment of linguistically and culturally competent providers

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	DATA SOURCES
2) To create opportunities for consumer, staff, and community input	1. Continuation of process for staff input into Cultural competence planning and activities	• Ongoing assessment of LME's cultural competence • Rotation of staff on CC committee	• Improvement in rating of cultural competence • CC committee minutes/attendance roster reflect staff rotation		• Cultural competence survey results • CC minutes/attendance roster
	2. Process of consumer/community input in the development of cultural competence plans, activities, and issues	• Demonstrate evidence of input from diverse advisory groups into refinement of CC plan • Continue existing partnerships to diverse community groups/agencies providing supportive services to diverse populations and develop new partnerships • Continue to provide updated information and progress of CC plan to CFAC, while requesting input and feedback	• CCAC has regular attendance by diverse community groups • Increase in numbers of partnerships w/ diverse community agencies/groups • Identify linguistically and culturally competent providers and distribute list to MeckLINK and advocacy groups • Feedback/input provided by CFAC		• CCAC meeting minutes, attendance roster. • # of active community partners • % of diverse ethnic/racial groups on advisory committees, boards, and planning groups • On-site assessment of linguistically and culturally competent providers • CFAC meeting minutes

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	DATA SOURCES
3)Implementation of CC plan	1. CC plan is regularly evaluated	• Complete final CC Plan document, to include opportunities for on-going amendments and improvement as it is implemented • Assessment of implementation/effectiveness of CC plan by CC committee • Regular review by CCAC and other groups • Continue to keep CFAC informed and solicit input/feedback	• Improvement in rating of cultural competence • CC committee minutes/attendance roster reflect staff rotation • Feedback/input from CFAC		• Cultural competence survey results • CC minutes/attendance roster • CCAC minutes • CFAC minutes
4) To align policies and procedures with culturally competent principles and practices	1. P&P are regularly reviewed and revised as needed	• Regular review and revision to ensure P&P are both culturally and linguistically competent • Review of provider agencies P&P and treatment practices to ensure alignment with CC principles and practices	• Assessments approve P&P or provide input for revision • P&P are approved by governing body • Provider agencies P&P and practices are linguistically and culturally competent		• Assessment results • Monitoring visits and other onsite assessment of provider agencies
5) To enhance Board members' understanding of the importance of developing a culturally competent agency	1. Board members are trained in cultural competence principles and practices	• Training of Senior management team in CC • Board regularly addresses cultural competence related issues as needed	• % of Board members completing CC training • Meeting minutes from Board reflect ongoing discussion of CC issues		• Training roster • Board meeting minutes

Goal #3

Year One –STAFF DEVELOPMENT: To improve efforts to ensure staff and service providers have the requisite attitudes, knowledge and skills for delivering culturally competent services.

Objective	INDICATORS	ACTVITIES	PERFORMANCE INIDCATORS	Time Line	DATA SOURCES
Staff performance And training	1. Staff Performance Review	• Attending trainings and classes – participation in various diversity events.	EPR	PSO Year 1 Fiscal Year end ---------- LME Fiscal Year end year 2	• EPR that are randomly audited by HR - ongoing.
Refine or develop recruitment	1.Standardized Questions	• Develop a questionnaire that includes questions for new hires and include in interviews at 90 days of hire and at exit.	Questionnaires	End of Fiscal Year 1	• Analysis of feedback
Recruitment	1.Training Booklet	• Updating training manuals for supervisors and managers in recruiting to include examples of interview questions and diverse sources to utilize and pull from.	Training Manual	End of Fiscal Year 1	• Training Manual
	2. HR Training Schedule	• Training to begin on recruitment and interviewing.	Classes	End of Fiscal Year 2	• Classes
	3. and Advertisements	• Ongoing advertising in newspapers that serve culturally diverse populations when budget permits and when there is a business need and verbiage to be used on postings in myHR to include proactive recruitment.	Advertisements & postings	Ongoing	• Advertisements and postings
Staff Plan	1.County Diversity Plan	• Continuous monitoring of needs and recruitment to achieve diverse workforces to accomplish the appropriate and effective services of consumers.	Plan developed by County	Ongoing	• County Plan

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	TIMELINE	DATA SOURCES
To continuously improve and update the training content for cultural competency	1. Evidence of a cultural competency in training curriculum and training plan 2. Assessment of effectiveness of CC training content 3. Assessment of CC of staff and agency included in consumer/community satisfaction survey	• Lunch and Learn and Spanish Lunch and Language. • Training Evaluation • CC pre and post assessments • Be consistent with training and events - ongoing • Train the Trainers- Not limited to AMH • Systems of Care and Service Definition Plan • Training Administrator to observe training. • Employee evaluation at end of each training	• Scheduled activities in MyHr • Eval Forms • Assessment Forms • Scheduled in MyHr • Questionnaire • Evaluation Form	End of Fiscal Year 1/ ongoing End of Fiscal Year 2	• Investment (monetary and other) in CC training (how many went through) • All staff complete initial and periodic CC training • Analysis of pre and post CC assessments • Consumer – Community Satisfaction Survey
To design and manage a process for coordination and dissemination of training opportunities for staff and reflect commitment to CC.	1. Number (%) staff completing initial periodic CC training 2. Documentation on how CC training is integrated into overall staff training activities. 3. NEO – what CC means. What we are doing, how they can be involved. 4. Results of regular monitoring and periodic evaluations of CC training efforts (pre and post evals)	• Reports in myHR • Training Administrator to audit all AMH trainings. • Training Dept will facilitate • QI Training Evaluation database reports.	• Query • Training Analysis • NEO • Evaluation Forms	Fiscal year end year 1	• HR database reporting • Analysis of Employee Development and training plan. • Analysis of pre and post CC assessments and training evaluations. • Analysis of reports
	Dissemination of information on staff training opportunities and policies and procedures.	• Results to be posted on SharePoint.	• Sharepoint website	End of Fiscal Year 2	• Overall staff development training plan reflects ongoing CC training activities.

Goal #4

Year One - COMMUNICATION: To enhance the exchange of information between the MAMHA/Providers and the consumer/population, and internally among staff, in ways that promote cultural competence.

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	Time Line	DATA SOURCES
1) To enhance understanding of different communication needs and styles of diverse consumer populations	1. Number of staff trained in use of interpreters	• Develop training materials in use of interpreters • Identification of staff positions needing training •	• Dissemination of training materials • Training sessions held as needed	• On-Going • On-Going	• Training records
	2. Presence of plan for culturally appropriate dissemination of written/other materials.	• Development of plan for culturally appropriate dissemination of written/other materials • Assessment of what diverse population groups need to be represented in plan • Development of onsite assessment tool • Collaborate with other community entities to increase availability of resources.	• Results of assessment(s) • Increased partnerships with the community stakeholders.	• June 2008 • June 2008 • July 2009	• Mecklenburg County census data • Penetration rate- to what consumer groups we are providing services? • Data from onsite assessments
	3. System of access to trained interpreters	• Establish uniform procedure for accessing interpreters	• Universal language access	• June 2008	• HR Records

2) To improve the avenues of communication within and between ethnically diverse consumers and communities.	1. Number of phone calls made to Mecklink.	• Develop a tracking log for LEP customers (Including TTY callers). • Develop capacity for quick turn around in answering calls for LEP customers.	• Increased number of calls at Mecklink reflecting LEP need. • Language/dialects of community available at point of contact and all levels of interaction.	• July 2009	• Mecklink phone logs.

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	Time Line	DATA SOURCES
	2. Number of community outreach and education sessions highlighting mental health concerns for diverse consumer groups and communities.	• Development of plan for attending community fairs • Provide presentations to diverse communities both by request and need. • Develop avenues to reach media audience i.e. local newspaper, television and radio talk shows.	• Increase number of calls at Mecklink reflecting LEP need. • Increase materials required for dissemination at community fairs. • Increased media presentation	• June 2008 • Ongoing • Ongoing	• Mecklink phone logs. • Child & Family Advisory Committee • Culture Competence Advisory Committee.
3) To improve Intra organization communication among and between staff and diverse employees.	1. Number of employees participating in Cultural Competence Training.	• Develop training plan to increase number of train the trainers. • Increase number of training sessions to build capacity within AMH. • Contract with Cultural Competence Consultants	• Increased number of trainers available within AMH. • All current and newly hired employees trained in the same CC curriculum. • Consumers/families receive culturally competent services either directly or indirectly.	• June 2008 • On-Going	• Training Department records • HR records • Customer satisfaction surveys. • Consultant's Evaluations • AMH CC plan
	2. Number of employees participating in Cultural Competence workshops, in-services and external opportunities.	• Provide opportunities for staff to participate in trainings i.e. Lunch & Learn. • Provide basic Spanish classes for frontline employees to communicate with LEP customers. Supplement bi-weekly classes to assist students with materials and conversation from lessons. • Disseminate information when available through the Grapevine. • Culture Competence Committee and Training Dept. working collaboratively to secure opportunities for employees.	• Increase number of employee attendance at Lunch & Learn. • Increased communication with Spanish speaking customers at point of contact. • Increased opportunities for employees to participate and provide feedback regarding desired events.	• On-Going • June 2008 • July 2009	• Training staff records. • Culture Competence Committee • Training Dept. records • AMH CC plan

<u>Year Two</u> - COMMUNICATION: To enhance the exchange of information between the MAMHA and the consumer/population, and internally among staff, in ways that promote cultural competence.

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	Time Line	DATA SOURCES
1) To enhance understanding of different communication needs and styles of diverse consumer populations	1. System for informing consumers of their right to interpretation and translation services.	• Revise Consumer Rights Handbook • Develop questions on Consumer Satisfaction survey	• Dissemination of Consumer Rights Handbooks • Increased use of appropriate interpreter services	• On-Going • On-Going	• Medical Records • Finance • Consumer Satisfaction Survey • Consumer Complaints
	2. Number of staff trained on use of interpreters	• Train selected staff on use of interpreters • Contract with consulting firm with certified interpreters • Administer needs analysis	• Appropriate use of interpreting services • Number of interpreters meeting consumer needs	• June 2008 • June 2009 • 3/31/08	• Training Roster • Questions on Consumer Satisfaction surveys • Internal surveys • Tracking contract usage
2) To improve the avenues of communication within and between ethnically diverse consumers and communities.	• Number of community outreach and education sessions held with target consumers.	• AMH participation in community events • Utilization of established community relationships	• Increased community inclusion	• Ongoing	• MeckLink phone logs. • MeckLink phone logs. • Child & Family Advisory Committee • CCAC
3) To improve Intra organization communication among and between staff and diverse employees.	1. Documentation of strategic/ processes to promote effective communication among diverse staff.	• Scheduling all related culturally competent training in MyHR. • Inform internal staff of culturally competence training and activities via email AMH-All, Grapevine Newsletter.	• Staff demonstrates cultural competence in communications with co-workers. • Improved inter-personal relationship	• On-going •	• Training Department records • MyHR records • Self Assessment Survey. • AMH CC plan

Objective	INDICATORS	ACTIVITIES	PERFORMANCE INDICATORS	Time Line	DATA SOURCES
	2. Assessments of workplace satisfaction, workplace climate and staff's competence in communications with co-worker	• Developing a joint assessment tool with the County Diversity Committee. • Create an AMH self assessment survey.	• Results of assessments greater than or equal to 85% or higher.	• June 2009	• Self Assessment Survey
.	3. Accessibility of resources .	• Scheduling training/events at times in which all employees can attend. • Scheduling multiple events simultaneously from a central location. • Accessibility of information via SharePoint. • AMH Culture Competence Plan	• Increase employee participation.	• On-going	• Leadership Team • Culture Competence Committee. • Training Department.
.	4. Cultural Competence Training .	• Providing basic culture competence awareness and understanding to all AMH employees • Training new trainers • Roll out level II of cultural competence training.	• Pre and Post Score. • Adding 10 new trainers. • Staff demonstrates higher level of cultural competence.	• June 2008 • June 2009	• Pre and Post Test. • Self assessment survey

Needs Assessment

- On-going, dynamic process
- Integrated into business practices
- Community collaborations and partnerships
- Needs of consumers are at the core

Needs Assessment – Guiding Principles of the Mental Health Reform

- Consumer and Family participation
- Person Centered Thinking and Person Centered Plans
- Within context of movement toward best practices
- Development of linkages to community resources, including natural resources
- Supporting consumers to reach self-sufficiency

Needs Assessment – What's available vs. what's needed

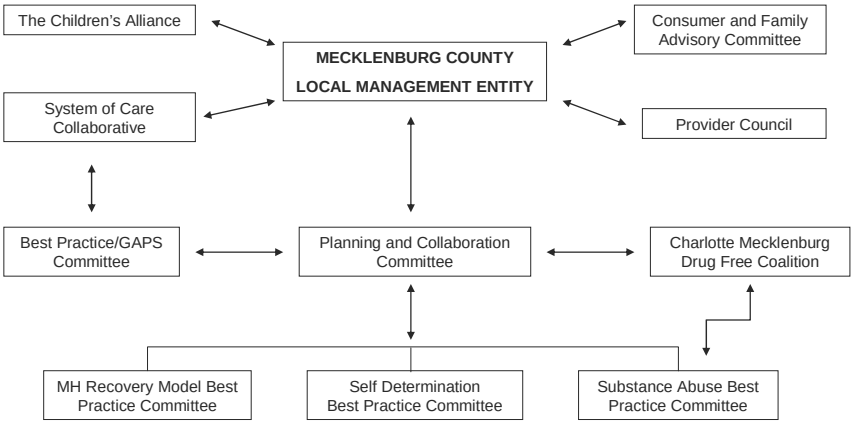
- Community Surveys and Reports
  - System of Care Service Availability Survey
  - Mobile Crisis Services Study
  - Youth Risk Behavior Survey
  - Youth Drug Survey
  - Substance Abuse Indicator's Report
  - Intensive Therapeutic Foster Care Survey
  - Warm Line Study

Needs Assessment – National Research and Benchmarking

- National Alliance for the Mentally Ill
- Substance Abuse & Mental Health Services Administration (SAMHSA)
- National Mental Health Consumer's Self Help Clearinghouse
- TASH (Inclusion for People with Disabilities)
- Ohio Department of Mental Health

Needs Assessment – Community Collaborations

- Strategic Advisory Committees
- Community "System" Partners
- Best Practices Committees
- Provider Council



Needs Assessment: Community Engagement

- Provider InfoShares
- Consumer and Family Focus Groups
- Consumer Interviews
- Consumer Specific Services

Needs Assessment: Examples of Service Development

- Community Activities & Employment Transitions
- Recovery Model Training Collaborative
- Peer Support Center & Warm Line
- Substance Abuse Integrated Dual Disorder Treatment Continuum
- Rapid Response Crisis Homes
- Clinical Service Array for incarcerated youth
- Prevention: Reconnecting Youth & Keeping It Real

Needs Assessment: Influencing Change

- Target new funds
- Redirect existing funds
- Flexibility in moving dollars
- Dollars follow the consumer
- Request for Proposal protocol